COLLABORATING FOR A HEALTHIER KING COUNTY

King County Region

Accountable Community of Health

Readiness Proposal

September 2015

Collaborating for a Healthier King County

King County Region - Accountable Community of Health Readiness Proposal

September 1, 2015

Community Transformation Team
Washington State Health Care Authority
626 8th Ave SE
Olympia, WA 98501

Via email: communitytransformation@hca.wa.gov

Dear Healthier Washington Team:

The King County Accountable Community of Health (ACH) Interim Leadership Council is pleased to submit this proposal demonstrating its readiness to engage in the next phase of ACH development. As the interim governance structure for the King County region, we request designation as the King County region ACH, and look forward to continuing to work together with state and community partners to improve health outcomes and health equity in King County.

As documented through this portfolio, the emerging ACH in the King County region has established structures and capacities for basic governance, engagement, communication, financial, and administrative functions. In 2015, an interim leadership council formed and has adopted a charter to guide its work. Work groups are underway and others are in formation. For backbone support, Public Health-Seattle & King County is carrying out a range of communications, convening, and administrative functions.

Most important, a range of health improvement initiatives are underway in the region, from those working to better integrate and coordinate care in the delivery system, to more upstream and place-based initiatives.

Building on both these interim structural elements and improvement activities, we intend to work together and with partners at the state and regional level to further develop, refine, and adjust an ACH governance structure and administrative functions to support successful, high priority health improvement initiatives that achieve the Triple Aim. We also recognize that the ACH initiative is in its formative stages and that its roles may be shifting. We therefore will look forward to engagement with the state and other stakeholders in assessing the ACH role in potential Medicaid Transformation initiatives.

For questions about this Readiness Proposal, please contact Janna Wilson (Janna.Wilson@kingcounty.gov) or Gena Morgan (Gena.Morgan@kingcounty.gov).

Sincerely,

Gena Morgan, Senior Program Manager, King County Accountable Community of Health
On behalf the King County ACH Interim Leadership Council

King County ACH Interim Leadership Council members:

Nancy Backus, Mayor, City of Auburn
Teresita Batayola, Chief Executive Officer, International Community Health Services
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Patty Hayes, Interim Director, Public Health – Seattle & King County
Betsy Jones, Health and Human Potential Policy Adviser, King County Executive's Office
Adrienne Quinn, Director, King County Department of Community and Human Services

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Category 1: Governance Structure

Following a period of initial ACH interviews and planning in the latter half of 2014, a group of community-based organizations, physical health, behavioral health, philanthropy, and government stakeholders mutually agreed to come together as an Interim Leadership Council (ILC) to guide ACH design in 2015 for the King County region. This structure was recommended by the 2014 consulting team, Cedar River Group and Watanabe Consultation, and documented in the December 2014 report, Collaborating for a Healthier King County: A Path Forward for ACH Design in King County, Washington.

The ACH ILC evolved from a previous cross-sector group of stakeholders in King County – called the Advising Partners Group - who had been working together to advise on the implementation of the *King County Health and Human Services Transformation Plan.* That group sunsetted at the point where the ACH Interim Leadership Council was formed.

The ACH ILC held its first meeting on May 7, 2015, and at its second meeting adopted by consensus a charter to guide its work for the year. The Charter lays out a set of values, roles, membership, scope of work, resources, committees and work groups, decision-making process, and a process for managing real or perceived conflict of interest.

This leadership council is an "interim" one because its work for 2015 calls for refining its governance structure as it works to understand in more depth the role of the ACH, including more explicitness of what it is intended to govern, why, and how. Therefore, the workplan and charter demonstrate both the intent to adjust, and a process for adjusting, its governance structure.

Supporting documents:

- Interim Leadership Council Charter
- 2015 Work Plan
- May 7, 2015 Meeting Summary
- June 10, 2015 Meeting Summary
- July 20, 2015 Meeting Summary
- August 21, 2015 Meeting Summary

Category 2: Governing Body Membership

The Interim Leadership Council serves as the current governance structure for ACH development in the King County region, and includes members from diverse sectors and systems that influence health and well-being.

Not *all* sectors that influence health are represented on the ACH ILC. During the development of the ILC, both the consulting team and the ad hoc steering committee recommended that the group be kept small to enable meaningful dialogue and cautioned against developing too much infrastructure too fast. This does not mean that others who are not part of the ILC do not have a voice or say in ACH development. The intent has been to use work groups and other methods of engagement in concert with the ILC to inform ACH development (see discussion under Category 3).

There are currently 23 members of the ILC representing 13 sectors based on seats that are co-held between two or more individuals. There are also activities underway to engage other participants, including Tribes, businesses, and community members, where seats are being held for those sectors on the ILC.

Supporting Documents:

- Interim Leadership Council Roster
- Steering Committee Roster

Category 3: Community Engagement Activities

The ACH Interim Leadership Council is one of several elements that are together intended to shape ACH development in King County. Others include:

- Participation in work groups and committees (including data/performance assessment; regional health improvement plan; sustainability, and physical/behavioral health integration).
- Reaching out to existing groups as "sounding boards" for ACH discussions. ACH staff have, for example, met with the Washington Health Alliance, the King County Board of Health, the King County Hospitals for a Healthier Community, and fellow ACH backbone entities. Staff presented in April 2015 on an ACH panel with the Health Care Authority and Better Health Together at a Faith and Health conference sponsored by African Americans Reach and Teach Health. In addition, there have been numerous one-on-one conversations with various sector leaders and interested parties in King County.
- Partnership with equity networks and coalitions. In both the ACH planning and design phases, a high priority has been placed on engaging with community/consumer networks to support engagement of those most affected by health inequities. Watanabe Consultation was engaged during the planning phase, and is continuing into the design phase, to facilitate the conversations and structural elements to put this value into practice. An ad hoc work group has now formed to design mechanisms for consumer/community voice at all levels of ACH governance and activities.
- Partnership with existing priority health improvement initiatives in the region, including Communities of Opportunity, Familiar Faces, Housing-Health partnership planning, and physical/behavioral health integration.
- In Communities of Opportunity, monthly co-design meetings with community partners are underway in the three partner sites (Rainier Valley, SeaTac/Tukwila, and White Center).
- The Familiar Faces initiative, in addition to the systems and organizations involved in planning, has incorporated people with lived experiences into the design work. This includes interviews with current clients as well as the creation of an advisory group of four former "familiar faces." The advisory group met for the first time on August 7, 2015.
- Public website and periodic stakeholder updates. A comment form is posted on the King County ACH website, and a public comment period is held at each meeting of the ILC.
- A broad stakeholder e-mail list of people interested in health and human services transformation efforts in King County, including the ACH, includes 750 people as of late July. Periodic updates are sent out via this network.

Supporting Documents:

- Chronology of Efforts Regarding Community Engagement/Inclusion in King County Accountable Community of Health (ACH) Planning and Design Work
- Meeting summaries of ad hoc work consumer/community voice work group – July 14 and July 20, 2015.

Category 4: Backbone Financial and Administrative Functions

At this time, Public Health-Seattle & King County is coordinating the financial and administrative activities for ACH development activities. This builds on the support that it had from community partners as the 2014 planning phase grantee for the region.

Playing this role builds directly on the convening and communication roles that the county played in the development of the Health and Human Services Transformation Plan, as well as Public Health's role as the convening entity for the King County Hospitals for a Healthier Community.

The work plan and charter for 2015 include an intent to have the Interim Leadership Council review and come to agreement on what entity or entities should play what administrative roles in the future. This is shown in the Visual Representation of Phased Approach to ACH Design that was included as part of PHSKC's design grant application materials. This intent is also referenced in the general communications piece, Overview of ACH Development in the King County Region. Discussions with the ILC about what entity or entities should carry out what administrative functions going forward are expected to occur in late 2015.

One of the "backbone" functions relates to data analytics designed to support the ACH needs for assessment, measurement, and evaluation. Public Health is bringing in-kind staffing support to a Performance Measurement Work Group (see charter and membership).

In addition, please see the King County ACH website as evidence of various communication activities that have been carried out by PHSKC, including general briefing slide decks.

Supporting Documents:

- Visual Representation of Phased Approach to ACH Design
- Overview of ACH Development in the King County Region (July 2015)
- Performance Measurement Work Group – Charter
- Performance Measurement Work Group – Members
- June 10, 2015 Meeting Summary
- July 13, 2015 Meeting Summary

Category 5: Regional Health Needs Inventory and Initial Priorities

Among the many sectors in King County that affect health and well-being, a wide range of strategic plans, assessments, and priority-setting processes are in place. Some are countywide in nature, others are local or neighborhood plans, and others relate to specific population groups or people with specific health conditions. While it is not possible to point to a single, shared set of cross-sector priorities at this time, there have been recent planning efforts that have worked to take a broad view of population health and the factors that influence health, both clinical and non-clinical. Initiatives such as Communities of Opportunity, Familiar Faces, and housing-health partnerships all made significant progress in the past year in engaging multiple sectors in their work to improve outcomes related to health, housing, justice system involvement, economic opportunity, and more.

In 2015, King County Hospitals for a Healthier Community – a collaborative of 12 hospitals and health systems and Public Health-Seattle & King County-- issued its first joint community health needs assessment. Among the priority areas it identified were access to care; behavioral health; maternal-child health; preventable causes of death (obesity, tobacco); and violence and injury prevention.

As part of the ACH governance structure, a work group has formed – the Regional Health Improvement Plan work group – to develop an inventory of assessments and their themes, and then consider an approach to a future Regional Health Improvement Plan. The group's inaugural meeting was July 24, 2015, and a draft inventory has been developed.

Supporting Documents:

- Summary – King County Community Health Needs Assessment 2015-16, King County Hospitals for a Healthier Community
- King County Board of Health Resolution 15-06
- Charter for Regional Health Improvement Plan Work Group
- Regional Health Improvement Plan Work Group Roster
- July 23, 2015 Meeting Summary
- Draft Inventory and Themes of Major Assessments in King County (Regional Health Needs Inventory)

Category 6: Pathway for Sustainability Planning

Sustainability planning for an ACH coalition is a critical and complex piece of the work ahead. The ACH Interim Leadership Council intends to convene a sustainability work group in fall 2015, and has begun the process of identifying potential members.

To date, there have been several opportunities for community stakeholders to learn about concepts such as shared savings and pay for success/social impact bonds, and how they are being applied in health improvement initiatives in other locations.

Also, a number of additional grant sources have been secured by various partnerships to advance cross-sector initiatives in the region, and some of these, such as Communities of Opportunity's Living Cities Integration Initiative award, are encouraging the testing of innovative financial strategies to support longer-term system change. Communities of Opportunity was one of several cross-sector initiatives recently featured in a Working Paper of the San Francisco Federal Reserve Bank, called "Pathways to System Change: The Design of Multisite, Cross-Sector Initiatives," available at: www.frbsf.org/community-development/publications/working-papers/2015/july/pathways-to-system-change-multisite-cross-sector-initiatives/.

Supporting Documents

- Draft Scope: Sustainability Work Group

Additional Activities

Other activities connected to ACH development not previously discussed include:

- **Behavioral health full integration planning**. A Physical and Behavioral Health Integration Design Committee is slated to be convened as a committee of the ACH Interim Leadership Council. The intent is to develop an integrated design model and critical path forward to achieve implementation of a fully integrated model before January 2020. In summer 2015, a "kitchen cabinet" representing various sectors has come together and is developing the membership and charter for that committee. A staff position to support the work is being funded by King County and was posted for competitive hire in August. In addition, a consultant is in the process of being engaged. It's anticipated that the full committee will hold its first meeting in October.
- **Housing-Health partnership planning**. Over the past year, several King County stakeholders were involved in a statewide Affordable and Public Housing Health Care Partnership Workgroup led by Mercy Housing Northwest. The goal in convening the workgroup was to provide guidance on developing a scalable, sustainable business model for housing-based health promotion efforts. Progress is reported in a status report found here: http://www.mercyhousing.org/file/Housing-Health-Partnership-Summary-2015.pdf.
- **Communities of Opportunity**. An initiative launched in March 2014 in partnership with The Seattle Foundation and designed with the ambitious goal of creating greater health, social, economic, and racial equity in King County. This initiative is co-designing strategies with community leaders in three cities/neighborhoods in King County: Rainier Valley, White Center, and SeaTac/Tukwila, catalyzing public and private resources to underinvested neighborhoods. More information can be found on the website.
- **Familiar Faces**. A systems coordination initiative launched in September 2014 for individuals who are high utilizers of the jail and who also have a mental health and/or substance use condition. This initiative uses LEAN principles to identify waste and duplication to design around the shared outcomes of better health, improved housing stability, reduced emergency department use, reduced criminal justice involvement, and improved client satisfaction. More information can be found on the website.

Supporting Documents

- Position Description – Physical and Behavioral Health Integration Manager

Summative Narrative

The Health Care Authority requests that this summative narrative provide an honest reflection on how the initiative is going to date, including lessons learned.

Visionary and adaptive leaders. The King County ACH design phase has been marked by both progress and challenges. The activities to date have centered primarily on the formation of an interim leadership council and affiliated work groups. Because the King County region is approaching ACH development by building on the earlier work of the King County Transformation Plan, there existed a platform from which to build a strong leadership council. A group of highly engaged leaders with longstanding commitment to improved health and well-being in the region—and who bring experience in working complex initiatives that require adaptive leadership skills – are now lending their time and expertise to engage in ACH development. They bring different experiences, perspectives, and realities to the table. Their reasons for engagement, level of interest, the time they can devote, and the degree of trust with others at the table all differ.

It takes time. The design work is slow – not an uncommon dynamic in collective impact partnerships—and the workplan for 2015 appears, in hindsight, to have been overly ambitious. For example, the leadership council intends to use learnings from a set of existing cross-sector initiatives to inform its evolution into a more formalized governance model, but to date there has been limited "bandwidth" to understand and extract those learnings, and pull them forward to the Leadership Council. This is work yet to come. In addition, the launch of the physical/behavioral health integration committee and a sustainability work group are taking longer than expected due to resource and time constraints. A key lesson is that getting to "action" and showing value-add in the short-term is highly challenging in this context.

Impact of potential shifts in the ACH's envisioned role. Progress has also been affected by the state's proposal to expand the ACH role to serve as the coordinating entity for a global Medicaid waiver's transformation projects. The Leadership Council has naturally been working to digest and understand the implications of that proposal, and staff have been working to respond to an uptick of inquiries from other organizations wanting to "get involved" in the ACH as well as engage in an amplified set of state-convened meetings, comment opportunities, and technical assistance sessions.

Putting values into practice: a mixed report. The King County ACH is also attempting to put into practice its equity and social justice value of engaging those who stand to be most affected by its work. This critical work takes time, relationship-building, trust-building, and resources. Building on work that occurring during the 2014 ACH planning phase, several thoughtful conversations have taken place with an *ad hoc* group about this, with a SIM-supported consultant, and some positive steps are underway and planned. However, the execution is still falling short of where it optimally should be, and moving too slowly, to live up to the stated value. State-level attention to and resourcing of this aspect could go far in bolstering a deeper level of inclusion across ACHs.

Capacity challenges - and the relationship to success. Overall, the ACH design work in King County remains under-resourced for what it is being asked to undertake during this critical developmental stage. Even with the extensive in-kind time of community partners that is being brought to bear both at governance level and in backbone functions, it remains a mismatch with the scope and complexity of the work. This is a time when the depth and quality of analyses, framing, dialogues, communication, and inclusion are critical in order to move the design work forward in a proactive fashion that results in the region developing ownership and buy-in to the ACH and its value proposition.

Promising building blocks. There are a number of promising developments and dialogues that the design phase is producing due to the SIM grant's infrastructure support. For example, a Performance Measurement Work Group is engaged in thoughtful discussions about regional shared data needs *vis a vis* the state data roadmap, and putting its backbone role into practice by working to support the data needs of initiatives such as Familiar Faces, the housing-health partnership planning, and place-based health improvement initiatives. ACH voice is now being more proactively incorporated into the Analytic, Measurement, and Interoperability (AIM) domain of Healthier Washington – a promising partnership between the state and regions that has not previously existed. And, a Regional Health Improvement Plan work group is bringing together leaders involved in assessment activities and plans across many sectors that improve health. These new relationships and partnerships are foundational building blocks that, over time, should set the stage to enable the region, in partnership with the state, to more effectively tackle its most complex health and social inequities and achieve the Triple Aim. They will also help assure balance as together we work through the needs for state-level standards and consistency across ACHs statewide, with the needs for regional-level innovation, tailoring, and ownership.

As the King County region moves forward into the next level (Phase 1) of ACH development, its approach will continue to adapt and be informed by the challenges and successes that it has experienced to date. Most importantly, it will continue its drive to coalesce around the transformation vision that, by 2020, the people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities.

GOVERNANCE STRUCTURE

- Interim Leadership Council Charter
- 2015 Work Plan
- Interim Leadership Council Meeting Summaries
  - May 7
  - June 10
  - July 20
  - August 21

King County Accountable Community of Health Interim Leadership Council CHARTER

PURPOSE

1. Background and History

In 2013, community and government partners came together to discuss ways they could more effectively address longstanding inequities in health and well-being for the people and communities of King County. This led to the King County Health and Human Services Transformation Plan, which charts a course for developing a better performing health and human service system in the King County region. It expressed a vision that, by 2020, the people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities.

During roughly this same time frame, Washington developed a health innovation plan, now called *Healthier Washington*. Recognizing that health is more than health care, one of the strategies called for in that plan is to build healthier communities through a broad, collaborative regional approach. The state is calling this regional approach "Accountable Communities of Health (ACH)" and intends to invest in its development using resources from a four-year federal grant from the Center for Medicare and Medicaid Innovation.

Given the synergy between the goals of the county-level transformation plan and the state's innovation plan, King County convened stakeholders to explore the ACH concept with the support of a $50,000 grant from the Washington Health Care Authority and a consultant team. This work led, in December 2014, to a report back to the community and the state called "*Collaborating for Healthier King County: A Path Forward for Accountable Community of Health Design in King County*." It recommended the creation of an "interim leadership council" (the subject of this Charter) in 2015 to work on ACH design for the King County region.

2. Purpose – Why is an ACH Interim Leadership Council forming?

The ACH interim leadership council is coming together with the intent to move the ACH to its next stage of development. A multi-sector group of leaders such as this is needed to build on the work of the 2014 ACH planning conversations.

Driven in part by timeline and deliverables of a Health Care Authority grant that is supporting design phase activities, certain agreements will need to be reached in 2015 about the functions and governance of the ACH going forward, and what entities will play what roles in the future to effectively mobilize the region around health improvement. This leadership council is an

"interim" one because its work will include recommending, by the end of 2015, an ongoing governance model.

3. Values held by the Interim Leadership Council

The following values express important, shared beliefs of the interim leadership council and will guide its behaviors and decision-making over the course of the year. They are drawn from values and principles expressed in the King County Transformation Plan, and in the Healthier Washington innovation plan.

The Leadership Council values:

- **Collective action to address complex problems**. The extent of health and social inequities in the King County region calls for mobilizing new approaches and partnerships, including a more intentional partnership with state-level government agencies. New approaches may mean changes from the status quo, and may involve difficult conversations at times.
- **Being adaptive.** ACH development is an iterative process with each other and with state partners, so flexibility is critical in all aspects. New information, barriers, and opportunities may surface as the work goes along. Allowing for adjustments throughout the year will be important to develop the ACH in a way that achieves buy-in from the many sectors that play roles in contributing to health and well-being of county residents.
- **Building on previous work.** Consider and incorporate the work from the ACH planning phase, including the community engagement team. Consider and incorporate the values and principles expressed in the King County Health and Human Services Transformation Plan.
- **Equity.** Work intentionally to eliminate racial, ethnic, socio-economic and geographic disparities in health and well-being. Without this focus, there is a risk that current power dynamics and structural racism in health care and governmental entities will drive toward roles and governance structures that perpetuate rather than eliminate inequities. For any given issue, this requires looking at who decides, who provides, and who benefits or bears the burdens.
- **Engagement of those most affected**. Populations and communities in King County who are most impacted by health and health-related inequities (i.e., neighborhoods, low-income groups, communities of color, and people with disabilities, among others) should be among those who are influencing ACH development and associated strategies for improving their health and the health of their communities. Putting this value into practice will entail intentional development and resourcing of capacity and mechanisms that support two-way communication so that on-the-ground context expertise shall be included in ACH development, governance, decision-making, and initiatives.
- **Efficiency and not "recreating the wheel."** Understand, value and build on existing work, expertise and roles where it makes sense to do so.

- **Transparency**. Work products associated with the interim council and its work groups will be made available to interested parties and the public.
- **Assuring that no one sector dominates.** No one participant or group of participants should control the direction, agenda, and decision-making of the interim leadership council or any of its work groups or committees.
- **Respect.** Leadership members come to the table committed to developing an ACH structure that will work for the region; will work in the spirit of mutual agreement and accountability to each other. They will put into practice the "Guidelines for Multicultural Interactions" (see page 11).
- **A focus on outcomes, results, and scale.** Work in ways that are clear about intended outcomes, align resources to achieve them, move to pay for value not volume, measure progress toward outcomes, continually improve practice, and take improvement strategies to scale for broader population health impact and lasting change.
- **The "Triple Aim":** Recognition that new designs working to improve health outcomes must be developed in ways that simultaneously pursue three dimensions: improving the health of populations; improving the client experience of care (including quality and satisfaction); and reducing the per capita cost of health care.
- **Accountability**. In this current stage of ACH design work, the Leadership Council recognizes accountability to mean:
    - Accountable in the broadest sense to the King County community at large for assuring an ACH design process that will be effective over time at driving improved community health and well-being and reduce disparities; and
    - Accountable to the individuals in the community who experience health and health-related inequities and who most need and will be impacted by the ACH's work; and
    - Accountable to one another, as fellow members of the leadership council, for what we may agree to, individually and collectively; and
    - Accountable to the state for the deliverables agreed to in the ACH Design contract.

MEMBERSHIP AND ROLES

4. Membership

Background. Initial membership of the interim leadership council was developed through the input of an ad hoc steering committee. Its counsel was to keep the size of the group small enough to achieve its objectives and allow for meaningful dialogue, but large enough to assure diversity of sectors, skills, and perspectives. It also sought to assure that representatives included people who were involved in or leading the four existing key cross-sector collaborations that were identified as priority initiatives whose work should inform ACH design.

Per the recommendations of the 2014 community engagement team, the ad hoc steering committee advised that two seats be dedicated to representation from community coalitions focused on eliminating health and social inequities. Finally, federally recognized Tribal partners may join the interim leadership council at any time.

Representation. The interim leadership council will comprise representatives from the following sectors/entities. For any sector, two people from different organizations may co-hold a seat, for purposes of assuring adequate sector representation and participation in meetings. For Medicaid managed care plans, all plans under contract with the Washington Health Care Authority are invited to participate. In cases where there is more than one representative from a sector, each sector would constitute one "vote" in decision making (see Decision Making Approach on page 8, for more discussion). Where there is one representative from a sector, a delegate can be sent to represent the member with advance notice to staff. Delegates can participate in decision making during meetings on behalf of their represented member.

- City of Seattle
- Sound Cities Association
- Hospital systems
- Community health centers (Federally Qualified Health Centers)
- Medicaid managed care plans
- Community mental health/substance abuse services
- Philanthropy
- Human services, via King County Alliance for Human Services
- Housing
- Regional Equity Network
- Healthy King County Coalition
- King County
- University of Washington – prevention/population health entities
- Muckleshoot Tribe – invited
- Snoqualmie Tribe – invited
- Seattle Indian Health Board – invited
- Business – to be invited
- Commercial insurer – to be invited
- Community member(s) impacted by health/health-related inequities – to be invited

5. Functioning of the ACH Leadership Council

The ACH interim leadership council will have a steering committee, three workgroups, and affiliations with four priority initiatives. An ad hoc committee on community voice, comprised

of ACH interim leadership council members and other interested parties, will be created to foster authentic partnering of community members with the ACH interim leadership council. The ACH Leadership Council may also elect to establish other work groups.

Steering committee

1. A steering committee will guide the work of the interim leadership council and its work groups. This committee is comprised of 4-7 leadership council members. This will include one interim leadership council member representative from each of the three workgroups, and up to four other members including at least one seat for an ILC community member representative, should a representative be interested. The purpose of the steering committee is to help assure that the approach to the design year is successful and achieves its deliverables by providing guidance to staff on issues and developments that arise between meetings, by helping develop leadership council meeting agendas, and by proposing modifications to approach or strategy that in turn would be taken to the full leadership council. The steering committee represents the interests of all ACH leadership council members.

Workgroups addressing "cross-cutting" roles of the ACH (these are associated with meeting deliverables laid out in the Health Care Authority Design contract)

1. Performance measurement workgroup
2. Regional health improvement plan workgroup
3. Sustainability workgroup

Affiliated groups associated with the four priority initiatives that will inform and connect to ACH design

1. Physical/Behavioral Health Integration – an ACH Committee
2. Familiar Faces management guidance team
3. Housing-health partnership planning group
4. Communities of Opportunity Governance Group

The four affiliated priority initiatives have separate processes to determine membership, and their structures may evolve over the course of the year. An intentional link has been made in the composition of the ACH leadership council to assure that one or more leadership council member is involved directly in the affiliated initiatives.

6. Meetings

A meeting series for the ACH interim leadership council has been established. The interim council may decide to add, cancel, or modify meetings as appropriate throughout the year to accomplish its business.

Project staff will work with the steering committee to prepare objectives for each meeting. Agenda and meeting materials will be distributed at least three (3) business days in advance. When a decision-making item is on the agenda, meeting materials will be distributed no fewer than five (5) business days prior to leadership council meetings. Project staff will record and distribute meeting summaries to the membership and post on the ACH website for other interested parties to access. Time will be set aside on the agenda of each leadership council meeting to allow interested parties to address and provide comments to members.

As part of the leadership council's equity value, members are encouraged to consider opportunities within their own organizations to build future leaders that reflect the diversity of the communities experiencing the greatest disparities in health and social outcomes. Where appropriate, providing opportunities for such future leaders to engage in work groups, attend leadership council meetings, or otherwise engage in this process is strongly encouraged.

7. Project Management and Facilitation

For ACH interim leadership council:

Project staff to support the work of the interim leadership council will be provided by King County with Public Health-Seattle & King County serving as convener. Staff roles will include but are not limited to assuring timely communication, supporting agenda development and meetings, providing relevant background information, analyses, and recommendations, especially in support of key decision-making, and participating in learning activities with other ACH regions. Project staff is funded in part with a portion of the Health Care Authority ACH Design grant, and in part through in-kind staffing.

Watanabe Consultation will strategize on approaches and activities throughout the year designed to cultivate inclusion of underrepresented voices and communities in the ACH design work. This work will build upon the guidance developed in the 2014 planning phase.

Leadership council meetings will be facilitated by project staff, but may also be facilitated by a neutral, external party as the work progresses and as deemed appropriate by the Leadership Council members.

For work groups:

Public Health-Seattle & King County will provide in-kind staffing to support the work of the Performance Measurement Workgroup and for the Regional Health Improvement Plan Workgroup. Support for a convening a Sustainability Workgroup was not identified at the time the charter was developed (due to resource limitations), but remains under exploration. King County Department of Community and Human Services will organize and fund lead staff and consulting support for the physical/behavioral health integration committee using in-kind resources.

OBJECTIVES

8. Scope and deliverables - What will the Leadership Council do?

The following list is based both on the decisions made in the previous 2014 planning phase, and on the requirements laid out in the Health Care Authority Design contract.

- Prepare a regional health needs inventory, and prepare a recommended process for a future regional health improvement plan and how it will be used.
- Develop a recommended governance model for implementation in 2016.
- Develop an initial plan for future sustainability.
- Recommend how administrative, financial, coordination, convening, communication, and data support functions (also called backbone functions) will be carried out in the future ACH structure, and assure a mechanism is put in place for periodic reaffirmation of the backbone organization(s) in order to allow for adjustments over time, as necessary.
- Throughout the year, work to assure coherence across a set of four existing priority initiatives, taking actions where appropriate to support their success. Use the learnings from these interactions to inform the recommended governance model.
- Provide input/recommendations to the state (and to the county/cities, where appropriate) related to health transformation elements such as physical/behavioral health integration, aspects of Medicaid purchasing, practice transformation hub, population health improvement plan, and issues connected to ACH development and functions.
- Develop an ACH Readiness Proposal no later than the end of 2015 in preparation for an entity/partnership to receive formal ACH designation.
- Endorse a model of care for full clinical and financial integration of physical health, mental health, and substance use disorder services, establishing a pathway forward for King County to achieve full integration including key phases, milestones and timelines.

- Facilitate decision-making about how to respond to new cross-sector health improvement initiatives/opportunities should they arise in 2015.
- As needed, endorse representatives from the King County ACH design region to serve on statewide work groups or advisory committees related to ACH development.

9. Duration

The ACH interim leadership council agrees to work together from May – December 2015. In late 2015, as part of an anticipated shift to an ongoing ACH structure, the leadership council will develop and execute a plan to transition from an interim to an ongoing structure. It is recognized that even the "ongoing" structure may need to adapt over time because structure should follow functions and functions may change over time.

10. Resources

Resources available for accomplishing this work include:

- **ACH Design grant -** $100,000 from the Washington Health Care Authority for the period April 17, 2015 – January 31, 2016.
- **In-kind support** from various organizations including the time of leadership council members and that of people serving on work groups
- **Technical assistance** (TA) to be accessed through the ACH TA contract award by the Health Care Authority to Empire Health Foundation.
- **The four initiatives of initial focus** have varying levels of resources specifically to support them and their governance, initiatives, and supporting functions. Resources are from a mix of aligned existing sources, philanthropy partners, and government.
    - Physical/behavioral health integration
    - Familiar Faces initiative
    - Housing-health partnership planning group
    - Communities of Opportunity

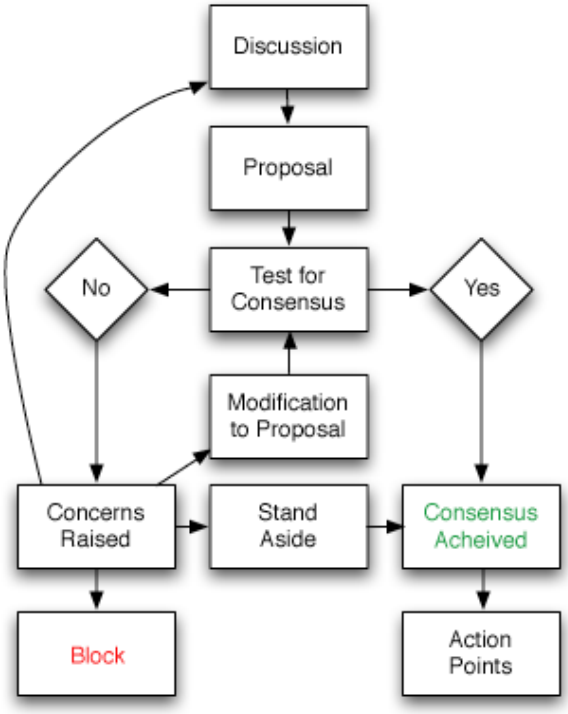
PROCESSES AND WORKING TOGETHER

11. Decision Making Approach

Because achieving voluntary agreement and buy-in from different sectors is foundational to the work and success of an ACH, the leadership council will make decisions and recommendations by consensus. The approach encourages putting the good of the whole above the interests of a single organization, and finding solutions that all parties support or at least can live with. Decisions will be documented in meeting summaries.

As part of consensus decision making process, any sectors that have more than one representative in attendance will be asked to caucus as appropriate and participate as “one vote or one voice” when making consensus-based decisions.

The following outlines the process steps in consensus decision making:[1]



Levels of agreement:

- I can say an unqualified "yes."
- I can accept the decision.
- I can live with the decision.
- I do not fully agree with the decision, however, I will not block it.
- I cannot live with the decision and will block it.

The leadership council aims to reach decisions by full consensus. The council will work to understand and integrate perspectives of all members until an agreeable solution can be found in a reasonable amount of time. Consensus may not mean 100% agreement on all parts of an issue, but rather that all members have reviewed a decision and are fully supportive, can accept the decision, can live with the decision, or do not fully agree, but will not block a decision. In

[1] "Consensus-flowchart" by grant horwood, aka frymaster - http://en.wikipedia.org/wiki/Image:Consensus-flowchart.png. Licensed under CC BY-SA 3.0 via Wikimedia Commons - http://commons.wikimedia.org/wiki/File:Consensus-flowchart.png#/media/File:Consensus-flowchart.png

the event that consensus is not possible, the leadership council can invoke "consensus-minus-one" and move forward with a decision or proposal with a maximum of one seat not supporting the decision.

Key decisions will be made in person at leadership council meetings. Members will be provided with adequate advance notice about decision items, and with a written "decision memo" that describes the issue, background, analysis including pros/cons, and staff recommendation. For more routine items, decision-making may be conducted over email and/or phone.

12. Managing real or perceived conflicts of interest

Conflict is to some degree inherent and expected in an endeavor that brings different sectors together to work on issues they can't address successfully on their own. The ACH leadership council acknowledges that conflicts, real or perceived, may surface in its work. This may occur within and among members of the leadership council, project staff team, state partners, and consultants working on the initiative.

The leadership council seeks to cultivate a culture of openness in talking about conflicts of interest. Many of its members as well as those in project staff and facilitation roles may have contractual relationships with one another and/or with the state, for example.

The leadership council will be intentional in identifying potential conflicts of interest. Members should raise or ask fellow members about potential conflicts related to the topics under discussion or decision making. Members, staff, and consultants should disclose potentially relevant conflicts, and then the leadership council should collectively decide how to address or manage the potential conflict on an issue-by-issue basis. Identified conflicts will be reflected, including dates on which those conflicts are declared, in meeting summaries.

Guidelines for Multicultural Interactions

Be present…Let go of anything that might be a distraction (deadlines, paperwork, children, etc.) and be intentional about your purpose in this moment. Bring your full attention to the process. Acknowledge anything that you need to let go of in order to be present.

Try on new ideas, perspectives … as well as concepts and experiences that are different than your own. Be willing to open up to new territory and break through old patterns. Remember, "try on" is not the same as "take on."

It's OK to disagree… Avoid attacking, discounting or judging the beliefs and views of others. Discounting can be verbally or non-verbally. Instead, welcome disagreement as an opportunity to expand your world. Ask questions to understand the other person's perspective.

Confidentiality…There is another dimension of confidentiality that includes "asking permission" to share or discuss any statement another person makes of a personal nature. It helps to remember that the story belongs to the teller.

Step up, step back… Be aware of sharing space in the group. If you are person who shares easily, leave space for others to step into. Respect the different rhythms in the room, it is ok to be with silence. If you are a person who doesn't speak often, consider stepping forward and sharing your wisdom and perspective.

Self awareness… Respect and connect to your thoughts, feelings and reactions in the process. Be aware of your inner voice and own where you are by questioning why you are reacting, thinking and feeling as you do. Monitor the content, the process and yourself.

Check out assumptions…This is an opportunity to learn more about yourself and others; do not "assume" you know what is meant by a communication especially when it triggers you – ask questions.

Practice "both/and" thinking… Making room for more than one idea at a time means appreciating and valuing multiple realities (it is possible to be both excited and sad at the same time) – your own and others. While either/or thinking has it place it can often be a barrier to human communication

Intent is different from impact… and both are important. It is also important to own our ability to have a negative impact in another person's life despite our best intention. In generous listening, if we assume positive intent rather than judging or blaming, we can respond, rather than reacting or attacking when negative impact occurs.

Listen deeply …Listen with intent to hear, listen for the entire content and what is behind the words. Encourage and respect different points of view and different ways of communicating. Engage heart and mind -- listen with alert compassion.

Speak from the "I"…is speaking from one's personal experience rather than saying "we," it allows us to take ownership of thoughts, feelings and actions

Laurin Mayeno and Elena Featherston, 2006
Adapted from VISIONS, Inc.

Updated 7-6-2015

Accountable Community of Health – King County ACH Design Phase Work Plan May – December 2015

MONTH	Interim Leadership Council Focus (Subject to Change)	Other Activities	Products This Month
MAY	**May 7** Shared grounding in ACH; priority strategies; critical path and work plan; charter; technical assistance needs	Work group meetings Development work related to community engagement in ACH design (with Watanabe Consultation)	• Leadership council charter • 2015 Work Plan (this document) • Stakeholder e-mail update
JUNE	**June 10** Discussion with guests from *Healthier Washington* about questions raised on May 7 Initial discussion of framework and timing of ACH designation criteria Approve Charter and Steering Committee	Work group meetings Physical/behavioral health integration committee (first meeting est. for late June)	• Stakeholder e-mail update
JULY	**July 20** Workgroup update and guidance, including Regional health needs inventory status *Potential item*: Discussion of Global Medicaid Waiver and proposed ACH role *Potential item*: Discussion about equity network/ coalition roles and consumer/community engagement	Work group meetings FYI: Health Innovation Leadership Network (HILN) meets July 24	• Draft of Regional Health Improvement inventory • Updated website • Stakeholder e-mail update
AUGUST	**Aug 21** *Potential action item*: Approval of	Work group meetings	• Application to HCA for King County ACH

MONTH	Interim Leadership Council Focus (Subject to Change)	Other Activities	Products This Month
	application from King County region for ACH designation Potential session on governance models in use elsewhere		Designation • Stakeholder e-mail update
SEPTEMBER	**Sept 10** Discuss recommendation on regional health improvement plan approach Governance model discussion part 1	Work group meetings	• Stakeholder e-mail update
OCTOBER	**Oct 19** Governance model discussion part 2 Sustainability strategies Recommendations from Performance Measurement Workgroup re: Future role, home, and structure of data and measurement functions	Work group meetings Hold ACH Stakeholder Forum # 1 (mid-Oct?) FYI: Health Innovation Leadership Network (HILN) meets Oct 16	• Stakeholder e-mail update
NOVEMBER	**Nov 16** Achieve consensus on governance model and backbone functions Discuss recommendation from physical/behavioral health integration committee		• Stakeholder e-mail update
DECEMBER	**Dec 16** Review public feedback Approve final ACH Proposal, with any agreed-on modifications Transition plan discussion and development	Approx Dec 1-8, public input on draft plan Hold ACH stakeholder forum # 2 during this time	• Stakeholder e-mail update • ACH Design Phase Report • Physical/ behavioral health integration design • Transition plan to shift to ongoing governance structure

King County Accountable Community of Health

Interim Leadership Council Meeting Notes

May 7, 2015, 9:00 a.m. – 12:00 p.m.

King County Elections Building, 919 SW Grady Way, Renton, WA

Members present: *Heidi Albritton (City of Seattle), Nancy Backus (City of Auburn), Teresita Batayola (International Community Health Services), Doug Bowes (United Healthcare), Michael Brown (The Seattle Foundation), Molly Carney (Evergreen Treatment Services), Elise Chayet (Harborview), Steve Daschle (Southwest Youth and Family Services), Erin Hafer (Community Health Plan of WA), Jeff Harris, MD (UW School of Public Health), Patty Hayes (Public Health), David Johnson (Navos), Betsy Jones (King County), Tao Kwan-Gett, MD (Northwest Center for Public Health Practice), Kris Lee (Amerigroup), Laurel Lee (Molina), Betsy Lieberman (Betsy Lieberman Consulting), Gordon McHenry, Jr. (Solid Ground), Adrienne Quinn (King County DCHS), Rebecca Saldaña (Regional Equity Network), Andrea Tull (Coordinated Care)*

Staff: *Gena Morgan, Janna Wilson, Holly Rohr Tran, Laurie McVay, Susan McLaughlin, Eli Kern, A.J. McClure, and Sharon Bogan (King County)*

Guests: *Amber Bronnam (Group Health), David Budd (Full Life Care), Carrie Glover (WithinReach), Daniel Gross (Northwest Health Law Advocates), Sybill Hyppolite (SEIU Healthcare 1199NW), Reena Koshy, MD (Fremont Family Practice), Maureen Linehan (City of Seattle, Aging & Disability Services), Siobhan Mahorter (Representative Eileen Cody), Suzanne Petersen (Seattle Children's Hospital), Caitlin Safford (Coordinated Care), David Stone (Sound Mental Health), Richard Waters, MD (Harborview Medical Center)*

Welcome, Introductions, Icebreaker

Janna Wilson welcomed council members and guests then introduced Gena Morgan, Senior Program Manager for the King County region's Accountable Community of Health (ACH) design phase and the Interim Leadership Council. Gena noted the inaugural meeting was designed for the members to get to know each other, develop a common understanding of the ACH initiative, and to define the approach and structure of how the council will work together. She shared an excerpt from a Living Cities article on solving problems through cross-sector partnerships:

> *"Instead of thinking about [cross-sector partnerships] as alliances of organizations which require representation from different sectors, they should be thought of as alliances of organizations which together have a role in solving a problem and achieving a shared goal."*

Gena then reviewed the agenda and led the group in icebreaker introductions for council members. Guests were invited to introduce themselves as well.

ACH Intent and Proposed Path Forward

Janna presented some grounding information regarding previous health and human service transformation planning in King County, the origin of the ACH initiative and its apparent intent, why the Leadership Council is convened, and the proposed path forward. See slides. After the presentation the council members were asked to form triads, discuss their hopes, questions, and concerns about the ACH design phase, then share with the group. The purpose was to surface key issues in order to understand the range of perspectives in the room, which in turn would be critical in refining the approach to the work ahead.

Hopes included:

- **Collaboration**: true and transparent collaboration and data sharing between and within sectors leading to the sharing of savings across those sectors; an inventory to help collaborators avoid duplication; organizational/institutional self-interests are set aside.
- **Alignment**: opportunity exists to align incentives (e.g., across housing, behavioral health, physical health) in support of common goals – can ACH help get to results and wins faster; can it help evaluate; and can regional groups and the State work toward similar measures. Support for a successful shift from Regional Support Network to Behavioral Health Organizations.
- **Scope**: large enough to include equitable focus for all age groups and social determinants; small enough to effect lasting change; focus goes beyond physical health to include mental health, behavioral health, chemical dependency, housing, and other social supports.
- **Community Engagement**: making the work real for low-income/no-income residents, consumers and community groups – enabling engagement in planning, governance, and oversight.
- **Financial Resources**: mechanisms created for shifting resources to where they are needed; fund prevention and basic needs that affect health like housing, jobs and food.
- **Results**: innovative and tangible solutions across multiple sectors that are scalable beyond pilot programs for larger impact.
- **Equity:** work to ensure that all have an equal chance at health and well-being.

Concerns and open questions included:

- **Scalability**: realistic expectations for moving the needle – need to be wise about the number of years it can take to see certain kinds of changes; how to get sufficient progress to keep up momentum beyond 2020.
- **Focus**: fundamental lack of clarity around the focus of the ACH – is it about improvements focused on the Medicaid population, or the broader population? Keep the broader vision of folks' health and well-being (including social determinants of health). Don't forget older adults.
- **Health Care Authority (HCA)**: what is their intent/role/responsibility; to what extent will the HCA establish standardization; are the HCA's efforts aligned with local efforts; what organizational/structural changes will the State make.
- **Data Alignment**: concern that each ACH region could create different data designs; questions raised about the linked initiatives (Communities of Opportunity, Housing-Health Partnership, Physical/Behavioral Health Integration Committee, and Familiar Faces) and the interaction of the ACH design with them.
- **Funding and Sustainability**: how will funding work in the years to come; how to get financial incentives aligned so they're not working at cross-purposes; initiatives not funded equitably; how to manage savings and investments; consider also political sustainability.
- **Sector Involvement**: where is the private sector – they should be included; private insurers and tribes needed; will all sectors give something up for the greater good.
- **External Factors**: policy changes will be necessary to achieve goals; maintaining efforts in the face of changing political will and/or leadership; the reality of funding, political context and leaders, and/or public relations can preclude organizational self-interest from being set aside.
- **Boiling the Ocean**: making the scope too large and hindering progress.
- **Accountability**: not clear who is accountable and how the work gets done.

The group reflected on common themes they heard during the sharing process. They noted that several people raised questions around the focus and intent of the ACH. Data integration, measurement, sustainability, and community engagement were other themes. The connection to the four "linked" existing initiatives was explored briefly. The group discussed how the ACH might be developed in a way that adds value by taking initiatives to scale, making sure the dots are connected across these kinds of health and social improvement initiatives, and capitalizing on the energy of sectors, such as housing, to be long-term partners in health improvement.

Review and Adjust Draft Charter

Gena walked the group through the draft charter and explained that the project team believes the charter is necessary to having a common understanding of the operating principles and "rules of the road" that will guide the work of the Interim Leadership Council in 2015. The goal of the discussion was to begin the process of achieving consensus on the elements of the charter. After the Council indicated their agreement that a charter was needed, Gena lead a discussion of four main sections of the draft, eliciting feedback.

Values: the draft charter lists 11 values under part three of the Purpose section. Gena asked if there were any values that didn't make sense and/or if anything is missing. Feedback and discussion points included:

- Should consideration be given to adding "scale" as a value? Focusing on small pilots and quick wins won't necessarily get us to improved population health. If we value taking improvements to scale, perhaps this should be called out.
- Should community engagement be pulled out as a separate value? How will we capture two-way communication with different populations and the community at large? It's about having people at the table shaping things and being involved in decision-making, not just reacting to proposals of others. The equity value isn't quite capturing this, several people noted. Staff agreed to add language to reflect the community engagement value.

Voting and shared Seats: addressed under the Membership and Roles section of the draft charter, Gena noted that the proposal is for each sector to have one vote (meaning one voice in a consensus decision-making process), even when the sector seat is shared among different affiliations. She also explained that membership and roles were developed with the values in mind, ensuring no one sector dominates. Feedback and discussion points included:

- The group again raised the issue of having a business/private sector representative at the table, such as a major employer. Conclusion was that the list of members should be modified in the charter to show one business seat and one commercial insurer seat.
- Separate seats for the federally recognized Tribes, if they elect to engage, are also being held (up to one each for the Snoqualmie Tribe, Muckleshoot Tribe, and Seattle Indian Health Board).
- Some discussion occurred about other apparent missing sectors. Staff and members explained that the earlier ad hoc steering committee that advised on the formation of the interim ACH Council wrestled through similar questions. In the end, they felt it was critical to keep the table at a size that could operate effectively, but should be supplemented through invitations to join a meeting, engagement outside of the meetings, and use of other "sounding boards" at key points during the process.

Structure: in addition to the existing workgroups, the staff recommended the creation of a Steering Committee, accountable to Council members. Gena noted that the purpose of the Steering Committee (SC) would be to provide guidance to staff on issues and developments between meetings and to help with agenda development. The thinking at this point is that the SC would include one ILC representative from each of the 3 current workgroups and

1-3 other Leadership Council members (total of 4-6 members), and would reflect people from different sectors. In addition, Gena called attention to the draft scopes for the three workgroups – Performance Measurement, Regional Health Improvement Plan, and Sustainability (currently unstaffed) – that were included with the meeting materials. Feedback and discussion included:

- Agreement that a Steering Committee should be created. Further work is needed to clarify and agree on membership.
- The draft scopes for the workgroups are acceptable at this time and provide enough information to continue moving them forward. The ILC would expect to see future versions as the scopes of work get further refined and to receive updates as the work gets started.
- Betsy Lieberman, who had earlier expressed interest/willingness to participate in the measurement work group, indicated a preference to shift to the sustainability work group.

Decision-making Process: staff recommends use of a consensus decision-making process. Gena explained the rationale, noting that given the nature of the work at hand, it stood to be more successful if it was designed in a way that built as much agreement as possible. Feedback and discussion included:

- The group discussed its decision-making process, arriving at an agreement that finalizing a decision could occur if the group achieved "consensus-minus-one." That is, that a decision/proposal could move forward in the case of unanimous agreement minus one vote.
- The group noted that major issues coming up for decision-making should be handled in-person at meetings to enable discussion and explore concerns.
- Each sector receives one "vote." Members must send a delegate in order to participate in in-person voting.
- Email voting will be utilized where appropriate (guidance from the Steering Committee could be helpful in determining what issues might be appropriate for e-mail, or not). If voting occurs by email, 100% participation would be expected for the consensus decision-making process.
- Request was made for all decision materials to be sent in advance and with adequate notice so members could take matters back to their constituents where appropriate. Also, there was a request for a decision memo to be provided that would lay out the issue, the options considered, and provide a staff recommendation.

Open Issues:

- Workgroups:
  - How will they be resourced?
  - How will the workgroups interact with the linked initiatives and their workgroups?
  - How are we defining "sustainability"? This may be an area for future discussion – does it mean sustaining the infrastructure of some kind of ACH governing group, or the innovations/improvement initiatives that the ACH seeks to carry out?
  - The need for subject matter experts participating in workgroups.
  - Who from the ILC will serve on which workgroups and on the Steering Committee? This will be handled in a follow-up e-mail.
- Health Care Authority (HCA):
  - What State support can be expected over the course of the initiative?

  - If the HCA is driving the program, what measures are they looking at to clarify and prevent spending time on broad goals that might not be aligned with the state's interest?
  - This discussion led to a decision to invite a representative from Healthier Washington to the next meeting, and to lay out some proposed discussion questions in advance. Staff will follow up to arrange this.
- Facilitation:
  - The major grant deliverable is an ACH Readiness Report submitted to the HCA.
  - At this time, the ILC does not have an external facilitator. Gena noted that she was a county employee, and the county also has a seat at the table as member. She opened it up for discussion about thoughts on outside facilitation going forward.
  - A few members indicated comfort with Gena continuing to facilitate for now. It was noted that members need to feel free to revisit this as the process goes along. It would certainly be possible to bring in an outside facilitator for conversations and decision-making later.

Conflicts of Interest: does the statement regarding this issue in the draft charter need more information or clarity? Feedback and discussion:

- The language seems to cover the bases, some members commented.
- The suggestion was made that if someone discloses a conflict of interest it should be documented in the minutes along with the date the conflict was disclosed.

Charter Next Steps:

- Workgroups are green-lighted to move forward; information and updates on their progress, together with revised scopes of work, will be communicated to Council members.
- Feedback will be incorporated into the draft charter and distributed via email to the Council for review.

Close and Next Steps

- Meeting summary and draft charter will be distributed for review late next week.
- Final summary and meeting materials will be posted to the ACH website.
- Members should let staff know about any potential interests they have in serving on work groups and/or the Steering Committee.
- ACH talking points in the form of a "one pager" for members to use with their partners and stakeholders will be created and distributed.

Meeting adjourned at 11:55 a.m.

King County Accountable Community of Health

Interim Leadership Council Meeting Summary

June 10, 2015, 1:00 p.m. – 4:00 p.m.

King County Elections Building, 919 SW Grady Way, Renton, WA

Members Present: *Heidi Albritton (City of Seattle), Tizzy Bennett (Seattle Children's Hospital), Doug Bowes (United Healthcare), Molly Carney (Evergreen Treatment Services), Elise Chayet (Harborview), Shelley Cooper-Ashford (Healthy King County Coalition), Steve Daschle (Southwest Youth and Family Services), Ralph Forquera (Seattle Indian Health Board, delegate for Teresita Batayola (International Health Services)), Erin Hafer (Community Health Plan of WA), Patty Hayes (Seattle-King County Public Health), David Johnson (Navos), Betsy Jones (King County), Laurel Lee (Molina), Betsy Lieberman (Affordable and Public Housing Group), Gordon McHenry, Jr. (Solid Ground), Adrienne Quinn (King County Department of Community and Human Services), Caitlin Safford (Coordinated Care), Rebecca Saldaña (Regional Equity Network), Ellie Wilson-Jones (Sound Cities Association, delegate for Mayor Nancy Backus (City of Auburn))*

Members Not Present, no delegate: *Michael Brown (The Seattle Foundation), Jeff Harris, MD (UW School of Public Health), Tao Kwan-Gett, MD (Northwest Center for Public Health Practice), Kris Lee (Amerigroup)*

Guests and Staff: *Gloria Albetta, Liz Arjun, Jennifer DeYoung, A.J. McClure, Susan McLaughlin, Laurie McVay, Gena Morgan, and Janna Wilson (King County), Wendy Watanabe (Watanabe Consultation), Carolyn Bonner (Highline Medical Center), Katherine Cortes (King County Council), Daniel Gross (Northwest Health Law Advocates), Sybill Hyppolite (SEIU Healthcare 1199NW), Nathan Johnson (WA Health Care Authority), Reena Koshy, MD (Fremont Family Practice), Maria Langlais (City of Seattle), Chase Napier (WA Health Care Authority), Lauren Platt (Providence Health Services), Ali Sutton (Bill and Melinda Gates Foundation), Andrea Tull (Coordinated Care), Trisha West (Evergreen Health)*

Welcome, Meeting Goals, and Agenda Review

Gena Morgan welcomed council members and guests. Gena called attention to the new faces around the table, including new council members and delegates. Council members introduced themselves and provided their reflections about the Accountable Community of Health (ACH) initiative over the past month. Gena then reviewed the three sections of the meeting's agenda; (1) a dialogue with Nathan Johnson and Chase Napier from the Washington Health Care Authority, (2) finalizing the charter and steering committee membership, and (3) a discussion of the framework for a potential King County ACH readiness proposal.

Healthier Washington: Dialogue about ACH Focus

Janna Wilson opened the dialogue by welcoming Nathan Johnson, Chief Policy Officer, Washington Health Care Authority (HCA) and Chase Napier, Community Transformation Manager, HCA. Following the leadership council's discussion at its May meeting, Healthier Washington leaders were invited to provide some clarity about core focus of the ACH.

Nathan Johnson began his comments by reviewing the overall goal of the Healthier Washington, and emphasizing that health transformation, to a significant extent, is about what happens locally and so one of the

roles of Healthier Washington is to support and empower the development of regional ACH structures. This concept came about in part from the input of regions during the development of the Healthier Washington Innovation Plan. He also emphasized that Healthier Washington is an initiative that is not just about the four-year State Innovation Model (SIM) grant, but that the grant is clearly a significant resource to support its implementation. He then reviewed the internal structure of Healthier Washington and how cross-agency teams have been formed in a way that seeks to model integration internally to get the work done, achieve milestones, make timely decisions, quickly address and resolve issues, and proactively collaborate and communicate. The first year of the grant is a planning year with an operational plan due to the Centers for Medicare and Medicaid Services (CMS) in December. He noted that CMS is very closely engaged in monitoring the progress.

Next, the discussion moved into a conversation about the core focus of the ACHs and what success would look like. Nathan stated the focus of Healthier Washington centers on three areas with the ACH envisioned to have a role in each: (1) physical and behavioral health integration; (2) clinical-community linkages, as a way to better address the factors outside the health care delivery system that affect health. He reviewed how 80% of what affects health is outside the delivery system, and about 20% is attributable to the care delivery system, but today most of the resources go the 20%. A Medicaid waiver could help in addressing this 80/20 situation. Finally, (3) value-based purchasing – if we are successful in making this shift, how can the ACH initiative play roles in assuring that savings get reinvested back?

Nathan spoke to the levers that are in place to support scalability and consistency statewide, such as the common core measures set, efforts to get data in the hands of communities, and statewide technical assistance so that a learning network takes root. There will also be appropriate regional variation, he said.

Next, the dialogue shifted to a conversation about the sustainability of the ACH through the grant years and beyond. Recognizing that regional pilots come and go, Nathan noted that this initiative was designed as a four-year process in order to demonstrate a business case for longer-term sustained investment in health improvement. Demonstrating success will be the key – it will be fundamental to show results and achievement of the Triple Aim. That will lead federal, state, and local partners to see the value in sustaining the work and the infrastructure. He reflected that if we all get to the end of this testing period and it turns out that the co-investment doesn't materialize, then the ACHs will not have demonstrated a case for sustainability. A key step forward will be to get clearer about what constitutes "savings" and how to quantify it.

A question was raised about sustainability from the vantage point of community engagement – how will the ACH engage and sustain the involvement of those most affected, especially low-income, communities of color, and refugee/immigrant groups, for example? Are there resources to support this? Chase responded that regions were working on strategies of "cascading" engagement, acknowledging that there are missing pieces and that authentic community engagement needs to be a priority going forward. One person noted that technical assistance was not the key need – it was actually resources to support the engagement work. Otherwise, the ACH work could end up choked and ineffective. It takes resources to really engage, and a deeper investment is needed, several noted. The size, diversity, and complexity of the region are factors that need to be taken into account.

The conversation concluded with a brief discussion of the global Medicaid waiver concept paper, and the thinking behind a proposal that a local-level entity like the ACHs serve as the coordinating entity. Nathan

explained some of the differences between Washington state and New York state's approaches (Washington is modeling many aspects of the waiver in New York).

It was asked whether waiver investments would address children as well as adults, and Nathan said yes, in the context of alignment with the areas of focus discussed previously (e.g. physical/behavioral health integration would apply to children as well as adults). The waiver concept paper is being reviewed by stakeholders, and a webinar is planned for June 15.

ACH Interim Leadership Council Charter and Steering Committee Membership

Gena walked through the changes in the draft charter for the interim leadership council. She also alerted the group that some additional input had just come in from one of the members not present asking for further considerations in the charter that would increase consumer voice and involvement in the ACH leadership council and its work. Because that input was received shortly before the meeting, and the group wanted to respect it and assure the space for processing it, staff was asked to follow-up with a review of the input and to take it up at a future leadership council meeting. The council reached unanimous consensus to adopt the charter with the following revision: that when an action/decision item is on the agenda, that materials be distributed no fewer than five (5) business days prior to council meetings. This was requested because many members need to take items back to their constituent groups and provide review time. There was also a request that meeting summaries be issued as soon as possible following meetings.

Gena called the group's attention to the updates on the status of the work groups included in the meeting packet. Susan McLaughlin provided an update on the status of the physical/behavioral health integration subcommittee, saying that a small kitchen cabinet was scheduled to meet soon to discuss membership and the launch of that group.

The council also reached unanimous consensus to accept the scope and membership of the Steering Committee. The managed care plans indicated that they may want to have the MCO representative rotate on a quarterly basis, and no objections were raised. One of the members said it will be important for the Steering Committee, as part of its work, to think about how the ACH can intentionally operationalize the values expressed in the charter.

Discussion of Potential King County ACH Readiness Proposal

Janna explained that the Health Care Authority would be issuing guidance on June 15 regarding the process by which ACH design regions would submit applications for ACH "readiness" and designation. HCA has laid out a set of categories in which they would expect to see concrete progress, such as developing a governance structure, interim or otherwise. Janna commented that when staff looked at the categories and expectations, it appears that the work to date in King County—even in its interim state—has made sufficient progress such that it may be close to meeting the markers for designation. Previously, staff was assuming that the ACH designation proposal would be something submitted around December. Even after designation, ACH groups are expected to continue to refine and adapt their governance structures, affirm who is playing what backbone support roles, etc., so doing this would not result in "locking in" anything about the current structures and roles. This is obviously critical because of the shifts in the environment – such as the fact that the HCA released a concept paper on a global Medicaid waiver that proposes a significant role for ACHs as coordinating entities, a role that

was not considered at the point when this group was formed. Chase noted that while there is flexibility and a recognition/expectation that structures will need to adapt, HCA also does not want to start new processes from scratch; it will be important to build on what's been developed. Janna noted that fundamentally, the work planned for the ACH leadership council this year to work on governance structure and how form can follow function wouldn't change. She asked for the group's temperature on potentially moving forward with an application for designation when the opportunity comes open, and also highlighted the resource challenge – in that funding for the staffing of this work will run out before the end of the year.

Several questions were raised about the implications of applying for designation early or waiting until later in the year, and what new expectations or deliverables would come with the next phase of ACH development after designation. Chase explained that ACH development (including contracting and corresponding funding) occurs along a continuum, so the phases are about achieving progress markers along that continuum. Applications will be accepted on a rolling basis, probably starting in August. Janna stressed that ACH designation, and readiness for that was not claiming readiness for playing a role relative to the potential global Medicaid waiver; she acknowledged that part of this work's group in the months ahead will be to talk about that very issue and its implications.

The group gave a "thumbs up" to having staff move forward, after reviewing the June 15 guidance, on drafting the portfolio for potential submission to HCA for designation, and aim toward approval of the application at the July 20 meeting if there is time to pull it together. Some members commented that the timing may be too ambitious for action in July. Given that members would need adequate time to review a designation proposal with their constituent groups, the ability to pull it together and provide vetting time before July 20 wasn't likely. This may be especially true due to the heightened interest and scrutiny in ACH development activities given the global Medicaid waiver concept paper that is on the streets. Staff indicated that they would put an August meeting on the books.

Close and Next Steps

Because the leadership council had earlier in the meeting approved its charter that included intent to provide a public comment period at each meeting, Gena asked the members if they wanted to add that to today's agenda. The group agreed, so Gena invited interested parties in the audience an opportunity to speak. Wendy Watanabe, a consultant working with the ACH staff team in King County, shared reflections on the community engagement issue, both about the lack of resources at the state level devoted to creating real space for community voice, and about the concern that community voice will be "squeezed out" further given the high stakes role for the ACHs that is now contemplated in the global Medicaid waiver. Daniel Gross with Northwest Health Law Advocates also recommended additional consumer participation mechanisms, and recommended the ACH ILC give further thought as to how its future substantive issues and agendas would be developed in a way that would be responsive to the community's interests.

Gena reviewed the action items, both those which arose from this meeting and a few carried over from the May meeting. They include:

- Quick distribution of the meeting summary
- Set up meetings of the Steering Committee and begin working with them
- Develop a one-page summary of ACH goals / elevator speech

- Potentially invite someone from California who has researched legal and governance aspects of ACH-like entities elsewhere to come and share information on national initiatives (potentially tapping into technical assistance resources)
- Follow up on the input received about community engagement, including coming back to the ILC with recommendations about it in July
- Revise the Charter document as discussed
- Begin work on developing the King County ACH readiness proposal
- Continue work reaching out to Tribes, business, and another insurer to join the leadership council.

Council members are encouraged to send a delegate in their place if they are unable to attend the meetings. Further, members may weigh in on scheduled consensus decisions prior to meetings they will not be able to attend via email to Janna or Gena.

The next meeting is scheduled for July 20th, at the King County Elections Building beginning at 1:00 p.m. Refreshments and networking begin at 12:30 p.m.

Meeting adjourned at 3:51 p.m.

King County Accountable Community of Health

Interim Leadership Council Meeting Notes

July 20, 2015, 1:00 p.m. – 4:00 p.m.
King County Elections Building, 919 SW Grady Way, Renton, WA

Members Present: *Heidi Albritton (City of Seattle), Elizabeth "Tizzy" Bennett (Seattle Children's Hospital), Elise Chayet (Harborview), Shelley Cooper-Ashford (Healthy King County Coalition), Steve Daschle (Southwest Youth and Family Services), Erin Hafer (Community Health Plan of WA), David Johnson (Navos), Betsy Lieberman (Betsy Lieberman Consulting), Gordon McHenry, Jr. (Solid Ground), Teresita Batayola (International Health Services) Kris Lee (Amerigroup), Tao Kwan-Gett, MD (Northwest Center for Public Health Practice), Jorge Rivera (Molina Healthcare of Washington, delegate for Laurel Lee), Caitlin Safford (Coordinated Care), Rebecca Saldaña (Regional Equity Network), Amina Suchoski (United Healthcare), Ellie Wilson-Jones (Sound Cities Association, delegate for Nancy Backus (City of Auburn))*

Members Not Present, no delegate:
Michael Brown (the Seattle Foundation), Molly Carney (Evergreen Treatment Services), Jeff Harris, MD (UW School of Public Health), Patty Hayes (Public Health), Betsy Jones (King County), Adrienne Quinn (King County DCHS)

Staff:
Gloria Albetta, A.J. McClure, Laurie McVay, Gena Morgan, Marguerite Ro, and Janna Wilson (Public Health – Seattle & King County), Wendy Watanabe (Watanabe Consultation)

Guests:
Jarrad Aguirre (The Gates Foundation), Carolyn Bonner (Highline Medical Center), Nicole Borsook (Evergreen Health), Susan Dyson (Evergreen Health), Daniel Gross (Northwest Health Law Advocate), Joy Lee (UW School of Public Health), Maureen Linehan (City of Seattle), Chase Napier (WA Health Care Authority), Suzanne Petersen Tanneberg (Seattle Children's Hospital), Marc Provence (WA Health Care Authority), Kathleen Southwick (Crisis Clinic), Ali Sutton (Gates Foundation), Andrea Tull (Coordinated Care)

Welcome, Meeting Goals, and Agenda Review

Gena Morgan welcomed council members, delegates and guests, including Amina Suchoski, who will be United's ongoing representative replacing Doug Bowes. After introductions, Gena provided an overview of the 5 primary goals for the day's meeting:

1. To gain an understanding of current Accountable Community of Health (ACH) developments and the landscape both in King County and across the State.
2. To get grounded in the progress of ACH workgroups to-date, providing feedback to help guide them in their work ahead.
3. To hear an update on the community engagement discussion that the Interim Leadership Council (ILC) talked about last month.
4. To understand the status of the Health Care Authority's pursuit of a global Medicaid waiver, and explore the implications of that on the ACH development work, including supporting the ILC in assessing whether any shifts or course corrections are needed for the ILC workplan and approach.
5. To hear from any interested parties. Gena noted that a public comment period is now a permanent part of the agenda, and she invited guests to sign-up if they wished to make a comment.

Gena noted that the values, which the ILC agreed upon in the charter, will be posted for each meeting at the suggestion of the Steering Committee.

ACH Developments – Check-in

Questions Related to Staff Report

This meeting's agenda packet included a staff report. Gena asked for any comments or questions about the report and flagged a few key items within it.

- A 4-page overview of the King County ACH was created by the staff and included in the meeting packet. Questions and comments were solicited from the members. The final version will be distributed to the members and posted on the website. A shorter 1-page "elevator" overview is coming soon.
- The website now has a public comment form. Feedback received via this medium will be shared with the Steering Committee (SC) and the ILC.
- Healthier Washington (HW) will be holding public meetings and webinars in August about the Global Medicaid Transformation waiver; the dates are listed in a supplemental handout provided to members. These meetings will be hosted by the Health Care Authority (HCA) and are open to the public.

Sharing of ACH Activities from Around the State

Gena asked for members to share about ACH activities they were aware of taking place around the state in order to support better alignment across ACH efforts in different regions. Several members provided information and updates on what is happening with ACHs across the state.

- Representatives from the health plans serve on each of the 9 ACHs across the state. They gave a brief update on where each region stands in their initiative development.
- Betsy Lieberman shared that the housing sector representatives involved in the regional ACHs engage in a monthly conference call to review housing specific issues and the progress in their regions.
- Tizzy Bennett noted that the hospital systems who are at the various ACHs around the state are now taking steps to coordinate with each other. Many questions have arisen around the global waiver concept.
- Teresita Batayola stated that community health centers are represented on all but one ACH, and are working together. One of their concerns is the lack of the specific inclusion of community health centers in the waiver concept paper.

Framework for ACH Readiness Proposal – Timeline

Gena Morgan reviewed the timeline for the King County readiness proposal; all dates are included in the staff report. Gena also noted that Healthier Washington conducted a site visit at the King County ACH on July 15. One take-away was that the next phase of the ACH initiative is not expected to have any direct implications or linkages to the global waiver and the proposed ACH role to coordinate certain aspects of the waiver. The next phase of ACH work post-designation will move current work forward regardless of what happens with the State's global waiver application.

ACH Workgroup Progress and Feedback

Performance Measurement Work Group

Caitlin Safford and Marguerite Ro (Public Health-Seattle & King County) gave an update on the Performance Measurement Work Group (PMW).

- Caitlin provided an overview of the group, and noted that it includes individuals with a broad spectrum of perspectives, which will allow the group to work in an effective way with the priority ACH initiatives and be effective at problem-solving issues that relate to data and measurement. Washington state representatives are on the group which supports alignment with the state's work on data and analytics.
- Marguerite shared that a new grant opportunity has come onto the radar screen that could support cross-sector data sharing, and that it was discussed briefly at a recent PMW meeting. The opportunity is the Robert Wood Johnson Foundation (RWJF) Data Across Sectors for Health (DASH) grant, which provides $200,000 over the course of 12-18 months to support community collaboration using shared data and information to increase their capacity for planning, implementing, and evaluating health improvement activities. Only 6 grants will be awarded nationally, and applicants need to be part of a cross-sector collaboration.
- Betsy Lieberman noted that with the funds so limited, it would be important to scope this carefully, and that a potentially good match could be to use this as an opportunity to integrate the wealth of data on housing from the King County Housing Authority and Seattle Housing Authority with the health, public health, and behavioral health data that Public Health-Seattle & King County and the Department of Community and Human Services currently have access to. This could support measurement and evaluation needs across multiple initiatives, including Communities of Opportunity, Familiar Faces, and beyond. Public Health is willing to work on a proposal.
- Some issues and questions around the DASH grant include:
    - Could/should the ACH ILC and its PMW serve as the oversight entity for this grant, if the project is invited to apply after the letter of interest phase? Janna Wilson noted that one of the roles of the ACH ILC is to help facilitate responses to new cross-sector opportunities that arise during the year, and does this potentially fall into that category?
    - It was noted that assuring Medicaid data was in the mix would be important. In addition, data on uninsured individuals, such as those served through community health centers, would not be captured by the Medicaid or other payer data sets, and this is something to consider going forward as well.
    - A comment was made that it could be very powerful, in the next community health assessment by the hospital community benefit collaborative, to have housing data included in the data sets that public health has access to.
- Public Health will move ahead to prepare a 5-page brief proposal and submit by July 29, and will reference the connection to the ACH/PMW. By September 1, it will be known whether or not the project is invited to submit a formal application, which would be due October 21. Staff will work with the Steering Committee to discuss details about what, if anything, might need to come back to the ILC related to the grant application in the event RWJF invites a full proposal.

Regional Health Improvement Plan Work Group

Gloria Albetta (Public Health-Seattle & King County) gave an update on the Regional Health Improvement Plan Work Group (RHIP).

- RHIP is currently under construction. The first meeting is scheduled for July 23. There are still two seats open, the Equity Network/Coalition Partner sector and the Mental Health/Substance Abuse sector. She noted that interested ILC members are welcome.
- The workgroup will compile the Regional Health Needs Inventory (an ACH requirement for designation). Further, and more important, they will work to prepare a recommended approach for development of the Regional Health Improvement Plan that will come back to the ILC.
- Gloria shared a draft of a grid that lays out existing assessments; she has been analyzing them to extract themes and encouraged the ILC members to let her know if there were assessments that they know about that should be included in this initial scan. She emphasized this was a draft and a conversation starter for the first meeting of the RHIP work group.

Community Engagement Discussion

Wendy Watanabe reported that on July 14, she facilitated a meeting regarding community/consumer voice and the ACH. It was in follow-up to the open issues raised at the June ILC meeting that needed more air time for discussion and processing. (In June, a commitment was made to return to the ILC with updates and recommendations). Wendy shared the highlights of the July 14 meeting.

- The grounding question that began the meeting was to determine what is driving the desire to engage the community at a deeper level. Three themes emerged.
    1. Multiple cross-sector populations, especially those most impacted by the work of the ACH, should be engaged around cross-sector issues
    2. Their voices should inform and shape decisions, not just be recipients of information
    3. That voice should be present at every stage and level of the ACH structure development
- Next, the group discussed some potential near-term action steps that would be feasible given the current status of ACH work. The meeting participants suggested the creation of a one-page summary to invite participation in two of the workgroups that were thought to be of highest interest (RHIP and PMW), together with personal outreach to potentially interested representatives. Staff are working to develop these invitations.
- Wendy noted that engagement is not the same as authentic partnering and that the small group will be working through what is required for community members to feel a sense of ownership.
- The community voice group will continue to meet as an ad hoc committee. It did not have time at the July 14 meeting to work on the proposed charter changes that were flagged at the June meeting. Those issues will be taken up by the group for discussion immediately following today's ILC meeting.

Discussion of Global Medicaid Transformation Waiver

Janna Wilson welcomed Marc Provence from the Washington State Health Care Authority (HCA). He has been at the HCA for a little over a month. His responsibilities reside within Medicaid Transformation initiatives and he has recently been given the added responsibility of the global waiver. Marc gave a high level overview of the State's global waiver approach.

- Washington State is proposing to have the ACHs act as coordinating entities and the vehicle of accountability for certain elements of the global waiver.
- Marc acknowledged that the language currently utilized by the state in reference to the waiver is in some cases vague because the waiver is in the process of being shaped and they are looking for

stakeholders to help shape it. He noted that filing the waiver application is the first step in a process that will present continued opportunity for engagement of ACHs and other stakeholders.

- The state will release the draft waiver application by the end of July. There will be a 30-day public comment period, during which HW will hold several public forums and webinars to elicit feedback from the state's communities. The state will then submit the application for review to the Centers for Medicare and Medicaid Services (CMS). The federal government will also hold a public comment period.
- Marc noted that no other states have a structure quite like what Washington is putting in place with the ACHs, and the state's intent to leverage the ACHs as part of the global waiver is an innovative approach of interest to CMS.

The ILC raised a number of questions regarding the implications of the global waiver.

- It was noted that acting as the delivery entity for global waiver funds is not the same role that ACHs were originally asked to play. There may be different skill sets required for managing the global waiver funds than those required for developing structures to enable cross-sector collaboration to improve the health of our communities, extend better care experiences, and lower costs. How will that be reconciled?
- How will the state balance the regional innovation with the statewide goals without creating a quilt that doesn't work together?
- In the mental health space, there was a question about whether an opportunity is being missed by Washington State to apply for planning grants that develop centers of excellence for behavioral health and bring reimbursement to community mental health centers that is similar to those of federally qualified health centers.
- What is the relationship of the waiver with accountable care organizations, which are already under development as vehicles for payment reform in our region.

Recognizing the importance and magnitude of the effect from the global waiver on the ACH ILC's exploration of a more formalized governance structure, staff raised the question about whether it would be worth considering engaging a facilitator to support the ACH governance conversations going forward. The proposed waiver role has made the conversation and work ahead both more complex and more time consuming, and more capacity is needed. In addition, there is the question of real and/or perceived conflict of interest arising from King County employees facilitating discussions that involve aspects of the global wavier.

- ILC members shared a number of viewpoints on this. Some felt it was reasonable and a good idea to bring in a facilitator, but more detail would be needed on the specific scope and skills (that is, not just a group process facilitator). Some felt the timing for this might be premature, or could detract from other needs such as focusing on community engagement. Staff suggested taking the matter up further with the Steering Committee.
- A "thumb" temperature check indicated that most members appeared supportive of bringing a facilitator on board, with a few people showing "sideways" thumbs indicating they had unresolved questions/concerns. This temperature check will be helpful to the Steering Committee during their discussion of the topic later in the week.

Public Comments

There were no public comments.

Close and Next Steps

Gena reviewed the action items which arose from this meeting, including:

- The King County ACH designation will be taken up and brought to a consensus decision at the August 21 ILC meeting.
- Keith Nagayama from ChangeLab Solutions in California has been invited to provide an educational session on ACH governance at the August 21 ILC meeting. Staff are working through the logistics of bringing him here, including the use of a pool of HCA technical assistance funding. The visit is not yet confirmed.
- Meeting summary will be distributed by the end of week.
- The ACH Steering Committee is meeting on Thursday, July 23.

Chase Napier asked the ILC members to keep in mind that ACHs will move forward with its work regardless of the global waiver, and that he would be following up with Gena and Janna about this.

Meeting adjourned at 3:56 p.m.

King County Accountable Community of Health

Interim Leadership Council Meeting Summary

August 21, 2015, 1:00 p.m. – 4:00 p.m.
King County Elections Building, 919 SW Grady Way, Renton, WA

Members Present:
Nancy Backus (City of Auburn), Elizabeth "Tizzy" Bennett (Seattle Children's Hospital), Doug Bowes (United Healthcare, delegate for Amina Suchoski), Elise Chayet (Harborview), Federico Cruz-Uribe (Sea Mar Community Health Centers, delegate for Teresita Batayola (International Health Services)), Steve Daschle (Southwest Youth and Family Services), Erin Hafer (Community Health Plan of WA), David Johnson (Navos), Adrienne Quinn (King County DCHS), Jorge Rivera (Molina, delegate for Laurel Lee), Caitlin Safford (Coordinated Care), Jeff Sakuma (City of Seattle, new member replacing Heidi Albritton), Rebecca Saldaña (Regional Equity Network)

Members Not Present
Michael Brown (The Seattle Foundation), Molly Carney (Evergreen Treatment Services), Shelley Cooper-Ashford (Healthy King County Coalition), Jeff Harris, MD (UW School of Public Health), Patty Hayes (Public Health), Betsy Jones (King County), Tao Kwan-Gett, MD (Northwest Center for Public Health Practice), Kris Lee (Amerigroup), Betsy Lieberman (Betsy Lieberman Consulting), Gordon McHenry, Jr. (Solid Ground)

Staff:
Gloria Albetta, Jennifer DeYoung, AJ McClure, Susan McLaughlin, Laurie McVay, Gena Morgan, Marguerite Ro, and Janna Wilson (King County), Wendy Watanabe (Watanabe Consultation)

Guests:
Sarah Addison (Sea Mar Community Health Centers), Carolyn Bonner (Highline Medical Center), Amber Bronnum, (Group Health), Maureen Finneran (Washington Dental Service), Daniel Gross (Northwest Health Law Advocates), Kathleen Southwick (Crisis Clinic), Troy Treanor (Snoqualmie Valley Hospital), Trisha West (Evergreen Health), Ellie Wilson-Jones (Sound Cities Association), Andrea Yip (City of Seattle)

Welcome, Meeting Goals, and Agenda Review

Gena Morgan welcomed leadership council members, delegates, and guests, including Jeff Sakuma, who will be City of Seattle's ongoing representative replacing Heidi Albritton. Gena also acknowledged Keith Nagayama, Senior Counsel at ChangeLab Solutions, who traveled from California to share lessons learned from California's Accountable Communities for Health (ACH) pilots. After introductions, Gena provided an overview of the primary goals for the day:

1. To begin to set the stage for upcoming Interim Leadership Council (ILC) governance discussions this fall by learning from a body of research conducted on ACH legal and governance considerations as part of California's ACH development.
2. To consider approval of the King County region's ACH designation portfolio for submission to the Health Care Authority (HCA).
3. To consider approval of changes to the ACH ILC charter which are being recommended by the community voice *ad hoc* committee to strengthen community/consumer inclusion.
4. To hear any brief updates on ACH developments from ILC members coming from their sectors as well as from any interested parties during the public comment period.

ACH Developments – Check-in

Tizzy Bennett noted the Regional Health Improvement Plan (RHIP) work group met the day prior. Gloria Albetta added that the meeting, their second, provided an opportunity for members to get to know one another. Discussion centered on the questions of a framework for RHIP intent and phases of work.

Presentation & Discussion of ACH Legal and Practical Considerations

Gena explained that at the first ILC meeting, several members expressed a desire to understand how new regional structures and ACH-related collaboratives were evolving in other parts of the country – what might we learn? To that end Keith Nagayama, Senior Council at ChangeLab Solutions, was invited to present an overview of their research into ACHs around the country. In addition to speaking with the ILC, Keith conducted a session earlier in the morning that about 40 other interested stakeholders participated in, both from King County and from around the state. Although California's approach to ACH design differs from Washington's in some important ways, some applicable lessons and a framework for thinking about governance and infrastructure may be helpful.

ChangeLab Solutions (CLS) conducted research on existing collaborative efforts to improve population health, researched applicable federal and California law that could impact the development and ultimate sustainability of an ACH, and engaged legal experts to assess both legal and practical considerations for creating an ACH. (Please see Keith's slide deck for further details).

Keith presented a framework that showed how they explored the strengths and challenges of different types of entities to fulfill various ACH roles (the key "choice points") against a set of principles. He noted that from his view there wasn't a clear-cut way to set up an ACH structure – much of that has to do with the specific community, what roles different organizations play, and levels of trust. Questions and discussion among the ILC touched on issues of engagement, funding, conflicts of interest, geographic size, transparency, and the different dynamics at play if administering resources (such as a wellness fund or waiver funds).

Public Comments

There were no public comments.

King County ACH Designation Application

The ILC next took up the matter of submitting the ACH readiness proposal to the Health Care Authority (HCA), which, if approved, would result in the emerging King County ACH structure being "designated" as the King County ACH. Designation would recognize the existing structure (even in its formative stage) in King County, and enable the region to access additional resources to continue ACH development. Activities for this next phase of development, called Phase 1, would be a continuation of the ACH work already in progress (e.g. governance, backbone capacity development, budget accountability structures, sustainability, RHIP, etc.).

A draft readiness proposal was initially shared with the ILC on July 31. Comments were received from one ILC member that primarily contained suggestions to include additional examples to strengthen the application. The August 14 draft is now under consideration for approval by the ILC.

Before checking for consensus, Gena opened the floor for member comments, issues, or questions about the application or the process.

- It was asked if any other entity was vying to become the ACH. Janna replied that since the planning process was set up by the HCA last year, she was not aware of any other organizing of a cross-sector group for this purpose. She reminded the group that the current structure will continue to evolve. One member noted appreciation for staff's efforts at transparency, including making the application available to the public.

- A visual temperature check via a thumb vote resulted in one sideways thumb, indicating an issue or concern. The concern was a request to clarify that everyone held the same understanding that designation was not suggesting or implying that the current ACH structure had the capacity and infrastructure to manage Medicaid waiver funds. Staff affirmed this understanding.
  - Gena noted that designation does not cement the current governance and structure, especially as the 1115 waiver adds so much uncertainty around a potentially expanded role of the ACHs. Designation is an indication of readiness to move into a next phase of development. The group also noted that the work of the ILC does not need to come to a hard stop at the end of 2015, and in fact moving to designation status comes with work expectations that would carry into 2016. More discussion is needed about continuing the work into next year.

With those issues clarified, the ILC signaled its consensus on moving forward to submit the application for designation. Further, the ILC indicated that it was supportive of having the application cover letter signed by Gena Morgan, as the Senior Program Manager of the King County ACH, on behalf of the ILC members.

The majority of the members not present had communicated their support to staff prior to the meeting. The one member whose vote had not been received would be notified and any concerns they might have would be discussed with staff.

Proposed Changes to the ACH Charter

Gena commented that the Consumer/Community Voice *ad hoc* Committee (CCV) has met three (3) times. Wendy Watanabe has facilitated the meetings and briefly reviewed the process taken up by the group. Rebecca Saldaña then walked the ILC through the proposed changes to the charter.

1) The language revisions involving values emphasize the community members' role and presence in shaping ACH decisions, not simply providing input. They specify accountability to community members impacted by the ACH work. The CCV suggested an additional value which would read:

   "Accountable to the individuals in the community who experience health and health-related inequities and who most need and will be impacted by the ACH's work"

2) In keeping with the sectors already listed for ILC membership, the CCV suggested that an additional sector, "community member(s) impacted by health/health-related inequities," be added. Recruitment should be taken up as soon as possible, recognizing that the seat may not be filled until after the ILC gives way to a subsequent structure given the time it can take. However, the CCV felt it was important to hold a place for this voice.
3) So that the community is represented at all levels of the ACH ILC, the CCV recommends adding an additional seat on the Steering Committee (SC) for an ILC community member representative.
4) Officially add the CCV as an ad hoc committee to continue thinking through the issues and to support/sustain community members' participation.

In its overview document, the CCV provided "other recommendations" to use multiple methods to include community perspectives and to provide financial support for community inclusion.

Questions and comments from the members included:

- Whether or not the "other recommendations" provided by the CCV should also be officially adopted into the charter. General consensus was that trying to include those recommendations in the charter would be overly tactical for this type of document. The revised language proposed provides the flexibility needed to be able to adjust as needs arise.

The ILC had unanimous consensus to amend the charter to include the language as proposed. They also took an action to endorse the CCV's "other recommendations" and asked that this also be recorded in the meeting summary.

Questions Related to Staff Report

Gena asked for any comments or questions about the staff report and flagged a few key items within it.

- During August and September, staff will be working with the Steering Committee (SC) on a consultant RFP. As discussed at the July meeting, the consultant will help tee up ILC sessions related to ACH governance.
- Staff will also work with the SC on reviewing the RFP and the selection process.
  - Gena invited any ILC members who have a strong interest in being involved in the process to contact her.
- Gena thanked members for their responses to the inquiry about potentially drafting a joint comment letter to the Centers for Medicare and Medicaid Services (CMS) responding to Washington State's application for an 1115 Medicaid Waiver (global waiver or 1115 waiver) and asked Janna to comment on next steps.
  - Janna noted the majority of ILC members supported the idea but a few wanted more parameters. The SC will take up the action of developing parameters and drafting a letter for review at the next ACH ILC meeting in September.
  - There was a brief discussion regarding the timing of the joint letter submission and the application negotiations that will take place between the CMS and the HCA. It was determined that if the HCA submits its application on August 24 as planned, CMS would reply by September 8 and indicate whether or not they will enter into negotiations with the HCA. At that point, a 30-day federal comment period would begin when CMS will receive public comments regarding the HCA application. At the point the ILC works on a comment letter, it is expected that it would not yet have insights into what questions CMS may be raising with the state.
  - It was asked if there was any movement among all the ACHs statewide to work on a joint comment, and Janna responded no, there was not.
- Healthier Washington hosted an all-day ACH Waiver Summit on August 10 for representatives of ACH regions statewide. Gena noted that, in addition to herself and Janna, Elise Chayet attended the session and asked her to comment.
  - Elise noted there were a lot of open questions from the session; that all are struggling with clarifying the proposed roles of different entities such as ACHs, MCOs, BHOs, and others. More clarification from the state would be helpful.
  - Federico Cruz-Uribe, who also attended the ACH Waiver Summit, commented that the state sees the ACH development timeline and 1115 waiver timeline as connected, and their intent is to have a correlated ACH/1115 waiver timeline.
  - Janna noted that, at some point, it appears the state would look to the ACHs to decide whether or not they will evolve into the role of managing the 1115 waiver Initiative 1 funds or if there would be another entity needed to fulfill that role.
  - Discussion among members continued, touching on topics such as level of risk, legal status implications, and conflict of interest issues. It appears that HCA will be continuing to engage with ACHs to talk about their proposed role in the waiver.

Close and Next Steps

- Staff will finalize the designation packet and submit it to the HCA around August 28. The final version of the application will be posted on the website. Only minor "housekeeping tweaks" will be made to the final version (e.g. including the meeting summary from the August 21 ILC meeting and replacing certain drafts of other documents with final versions).

- The Steering Committee meets on August 31 and will take up:
  - The September 10 agenda
  - Approach to drafting the joint letter to CMS
  - Reviewing a draft RFP for a consultant

The next meeting is scheduled for September 10, at the King County Elections Building beginning at 1:00 p.m.

Meeting adjourned at 3:56 p.m.

GOVERNING BODY MEMBERSHIP

- Interim Leadership Council Roster
- Steering Committee Roster

King County Accountable Community of Health

Interim Leadership Council, 2015

Name and Affiliation	Sector(s)
Jeff Sakuma Health Integration Strategist City of Seattle, Human Services Department	*Local government; Seattle-King County Area Agency on Aging*
Nancy Backus Mayor City of Auburn	*Local government; Sound Cities Association*
Teresita Batayola Chief Executive Officer International Community Health Services	*Community health centers*
Elizabeth "Tizzy" Bennett Director, Guest Services and Community Benefit Seattle Children's Hospital **Elise Chayet** Associate Administrator, Clinical Support Services and Planning Harborview Medical Center	*Hospital systems*
Amina G. Suchoski Vice President, Marketing & Business Development United Healthcare Community Plan **Erin Hafer** Director of New Programs Integration and Network Development Community Health Plan of Washington **Kristine Lee** Director of External Affairs Amerigroup Washington, Inc. **Laurel Lee** Vice President, Community and Member Engagement Molina Healthcare of Washington **Caitlin Safford** Manager, External Relations Coordinated Care	*Health Plans*
Michael Brown Vice President, Community Programs The Seattle Foundation	*Philanthropy*
Steve Daschle Executive Director Southwest Youth and Family Services **Gordon McHenry, Jr.** President and Chief Executive Officer Solid Ground	*King County Alliance for Human Services*

King County Accountable Community of Health

Interim Leadership Council, 2015

Name and Affiliation	Sector(s)
Jeff Harris, MD Director, Health Promotion Research Center School of Public Health, University of Washington **Tao Kwan-Gett, MD** Director Northwest Center for Public Health Practice	*Population health; Academia*
David Johnson Chief Executive Officer Navos Mental Health Solutions **Molly Carney** Executive Director Evergreen Treatment Services	*Community mental health and substance abuse services*
Betsy Lieberman Consultant Affordable and Public Housing Group	*Housing*
Rebecca Saldaña Co-chair, Regional Equity Network and Executive Director, Puget Sound Sage	*Regional Equity Network is focused on transforming power and outcomes to achieve racial equity*
Shelley Cooper-Ashford Governance Team, Healthy King County Coalition and Executive Director, Center for MultiCultural Health	*Healthy King County Coalition is focused on mobilizing communities to achieve health equity*
Patty Hayes Interim Director Public Health – Seattle & King County **Betsy Jones** Health and Human Potential Policy Adviser King County Executive's Office **Adrienne Quinn** Director King County Department of Community and Human Services	*Local government; local public health; King County*

King County Accountable Community of Health

ILC Steering Committee

NAME AND AFFILIATION	SECTOR(S)
Elizabeth "Tizzy" Bennett Director, Guest Services and Community Benefit Seattle Children's Hospital	*Hospital systems*
Caitlin Safford Manager, External Relations Coordinated Care	*Health plans*
Steve Daschle Executive Director Southwest Youth and Family Services	*King County Alliance for Human Services*
Betsy Lieberman Consultant Affordable and Public Housing Group	*Housing*
Rebecca Saldaña Co-chair, Regional Equity Network and Executive Director, Puget Sound Sage	*Regional Equity Network is focused on transforming power and outcomes to achieve racial equity*
Shelley Cooper-Ashford Governance Team, Healthy King County Coalition and Executive Director, Center for MultiCultural Health	*Healthy King County Coalition is focused on mobilizing communities to achieve health equity*
Betsy Jones Health and Human Potential Policy Adviser King County Executive's Office	

SUPPORT STAFF	AFFILIATION AND ROLE
Gena Morgan gena.morgan@kingcounty.gov (206) 263-8518	**Senior Program Manager** Public Health-Seattle & King County *Manager for ACH design phase*
Janna Wilson janna.wilson@kingcounty.gov (206) 263-8281	**Director of Health Policy and Planning** Public Health-Seattle & King County *Overall ACH design phase oversight.*
Laurie McVay laurie.mcvay@kingcounty.gov (206) 263-1294	**Administrative Specialist** Public Health-Seattle & King County *Administrative support activities*
Wendy Watanabe wendywatanabe@comcast.net (206) 547-4634	**Consultant** Watanabe Consultation *Advises on engagement of and power sharing with underrepresented communities in ACH design*

COMMUNITY ENGAGEMENT ACTIVITIES

- Chronology of Community Engagement and Inclusion Efforts
- Ad hoc Community/Consumer Voice Work Group Meeting Summaries
  - July 14
  - July 20

Chronology of Efforts Regarding Community Engagement/Inclusion in King County Accountable Community of Health (ACH) Planning and Design Work
As of 7/6/15

Note: The purpose of this document is to record the major activities undertaken to increase community voice in the formative stages of ACH development, and highlight successes and challenges so that we can learn from them and strategize together on next steps. It is a "living" document and will be updated periodically.

Action Taken	Explanation and Lessons	Time
1. Secured initial resources to begin the dialogue about inclusion of community voice in early ACH planning	In developing the application to the Washington Health Care Authority for the ACH initial planning grant, King County had consulted with community partners about overall approach. This led to 40% of the initial ACH planning grant (2014) being dedicated to initiating conversations around the design of a community engagement/inclusion strategy in ACH planning. Through a competitive RFP[i], Watanabe Consultation was selected to facilitate this element. Key Considerations/Lessons: The original methods and scope envisioned for this part (i.e., to build out broad community input via community-sponsored dialogues supported by small grants) had to be redesigned to fit within the compressed time period.	July 2014
2. *Ad hoc* community engagement team produced recommendations to be carried out in ACH design work	Watanabe engaged local leaders connected to networks of vulnerable and underserved populations, and invited them to a series of meetings to begin laying the ground for design of consumer/community engagement mechanisms in the ACH design work that was just beginning. Three meetings were held in late 2014 of a group referred to as the "community engagement team." The group's work shaped the direction of ACH design in King County, detailed in "Collaborating for a Healthier King County: A Path Forward for ACH Design." The "path forward" included recommendations for building community voice and power in the subsequent phase ACH design work in 2015 and beyond, calling for: - Building out a relationship with an equity network hub or coalition that would be an integral part of the ACH governance structure and 2015 design work[ii] - Two seats on the ACH governance group to be dedicated to grassroots equity network or coalition	Third quarter 2014

Action Taken	Explanation and Lessons	Time
	participation in the to-be-formed ACH interim leadership council. - Working to identify funding for a staff person/policy aid to support the participating network representatives to engage in ACH design work - Working to identify funding for activities that may occur among network members related to ACH engagement, as they unfold in the future. Key Considerations Lessons: Community engagement team raised challenges about this process, such as how hard it is to build inclusion at the front end on an initiative that is pretty abstract and conceptual. Raised the concern of "feedback fatigue" from siloed efforts separately asking for community input.	
3. Exploration of potential grant opportunity (not pursued)	*Acting on the recommendations detailed in #2*: Watanabe Consultation and Public Health staff evaluated a potential grant opportunity, the Institute for Healthcare Improvement SCALE initiative, providing up to $60,000 over 20 months. However, the short time frame for responding precluded an application due to the time required to coordinate among partners Key Considerations and Lessons. Funder timelines can be a mismatch with the time needed to connect with partners to explore opportunities and prepare applications.	February 2015
4. Formation of ACH interim leadership council	*Acting on the recommendations detailed in #2*: The Regional Equity Network and Healthy King County Coalition agreed to fill the two seats on the interim leadership council. Current representatives are Rebecca Saldana and Shelley Cooper-Ashford. Key Considerations and Lessons Challenges of asking any representative(s) to represent the breadth of diverse communities and working out the process.	March-May 2015
5. Resources budgeted in state ACH	*Acting on the recommendations detailed in # 2*: In the 2015 ACH Design Grant of $100,000, Public Health-	April 2015

Action Taken	Explanation and Lessons	Time
Design Phase grant to continue engagement planning	Seattle & King County budgeted $15,000 for: - Resources to continue consultant engagement with Watanabe Consultation - Resources to provide partial financial support for the time of equity network leaders' participation in ACH meetings. <u>Key Considerations and Lessons</u> Low level of state resources in the ACH initiative to address complexity of community engagement among diverse King County stakeholders.	
6. ACH session organized at AARTH's Intersection of Faith and Health Conference	*Acting on the recommendations detailed in # 2*: King County and Washington State ACH staff responded to invitation from AARTH (African Americans Reach and Teach Health) to organize a session at the conference focused on ACH and engagement of the faith community. AARTH had participated in the 2014 community engagement team. Facilitated by Watanabe Consultation, the session sparked further dialogue about and reflections on engagement of under-represented communities in ACH design, and how to boost partnerships through working with the faith community and its capacities.	April 25, 2015
7. Application for funding submitted by Regional Equity Network	*Acting on the recommendations detailed in # 2*: The Regional Equity Network (through fiscal agent Puget Sound Sage) applied for $50,000 to Pacific Hospital PDA Nimble Fund. Grantwriting support provided by Watanabe Consultation. Resources would have increased capacity of the equity networks at the ACH table by funding a part-time policy aid/analyst. Application was not selected for funding. <u>Key Considerations and Lessons</u>: Intent is to resource an intentional build-out of community-based infrastructure to participate in multiple decision tables and processes. Challenge is how to communicate this is not just about the ACH, but an attempt to address the larger community "feedback fatigue" by creating an ongoing mechanism.	May-June 2015

[i] **Excerpt from 2014 Request for Proposal explaining intent***: Why is there a need for a community engagement and inclusion consultant/entity?* The extent of today's racial/ethnic, social, and geographic health inequities makes it essential that the ACH design and governance include mechanisms for the *ongoing* engagement and influence of diverse communities (that is, that extends past the initial planning phase). Without intentional focus on the design of such mechanisms, there is a risk that current power dynamics and structural racism in health care and governmental entities will drive toward roles and governance structures that perpetuate rather than eliminate inequities.

Because the ACH structure is evolving, there is no playbook for how best to approach the meaningful inclusion of diverse communities in the August-December 2014 planning phase, nor is there a template for what ongoing mechanisms for meaningful engagement in an ACH structure should look like. This body of work goes beyond the traditional exercises of gathering input and feedback. The purpose of this consulting engagement is to establish a process that creates space for meaningful community interaction so that, in these earliest stages of ACH development, historically underrepresented communities can have influence in shaping an ongoing role in an ACH's activities.

[ii] **Equity network hub concept** as described by the 2014 community engagement team:

- Acts as a central hub for the work of multiple local "spokes" (grassroots groups/coalitions/organizations) working to engage, listen to, organize and empower community for greater equity. Taps existing entity (ties) to act as regional network host that encompasses multiple sectors.
- Holds a common equity vision across communities and sectors to foster community strength and resilience.
- Serves as conduit for support of broad based community participation through stipends and/or reimbursement for participation costs (e.g., interpretation/ translation, transportation, childcare) to develop community-defined and driven agendas by sub-regions.
- Acts as a learning community and community of practice and a pipeline for expanding the pool of community-based leadership (individuals and groups).
- Brings learning and community priorities to ACH decision making as well as other key decision making tables.

King County Accountable Community of Health

Community Engagement Discussion

July 14, 2015, 10:30 a.m. – 12:30 p.m.
Chinook Building, Conference Room 1312

Members Present: *Shelley Cooper-Ashford* (Healthy King County Coalition), Daniel Gross (Northwest Health Law Advocate), Kris Lee* (Amerigroup), Rebecca Saldaña* (Regional Equity Network), and Ali Sutton (Gates Foundation)*

*ACH Leadership Council member

Staff:
A.J. McClure, Gena Morgan, and Janna Wilson (Public Health – Seattle & King County)

Facilitation:
Wendy Watanabe (Watanabe Consultation)

MEETING PURPOSE

- Understand the current charge, tasks, and focus of the ACH Interim Leadership Council
- Understand recommendations from 2014 planning phase and actions taken to date
- Identify goal(s) for community engagement
- Discuss ideas about achieving community/consumer voice (CCV) into the ACH
- Identify considerations for CCV; e.g. changing conditions, resources available and/or needed

DISCUSSION HIGHLIGHTS

1. We reviewed context
   - A community engagement "team" was formed last Fall/Winter to consider community engagement, made up of representatives from a variety of populations and geographic areas. The 2 positions on the ACH ILC held by representatives of equity networks/coalitions, i.e., HKCC (Shelley) and Regional Equity Network (Rebecca) resulted from the team's discussions.
   - The equity network hub model focused on using coalitions of community/consumer constituencies to act as an *ongoing mechanism for engaging and informing community and conveying their input/feedback to the ACH deliberations.*

2. We discussed the focus and role of ACH Interim Leadership Council and its work groups, such as:
   - Will work to agree on a more formalized governance structure - grant deliverable
   - Define future supportive infrastructure and roles needed to support/inform ACH health improvement initiatives (e.g., data, financing, assessment/priority setting)
   - Develop approach to a future regional health improvement plan and priorities
   - Ensure equity in ACH ILC discussions; manage changing demands/circumstances affecting the ACH and ensure transparency and community voice

3. We identified goals for Community Engagement
   - See Conclusions

4. We raised some questions
   - *What is the timeline for the ACH ILC vs. permanent ACH?*
     Generally year end but may not be a hard stop because processes and potential roles are evolving
   - *Is there some way of linking this effort to the community engagement of Communities of Opportunity?*
   - *ACH ILC - advisory role or decision maker?*
     Think of it as partners coming to mutual agreement about governance (like an international treaty)

DISCUSSION CONCLUSIONS

Goals of CCV in the ACH

1. Engage multiple populations around cross-sector issues: e.g. health and other related issues and/or social determinants.
2. CCV should inform and shape ACH decisions
   - Empower and change power dynamic as well as being informed about ACH
   - Capitalize on other community input opportunities to inform ACH, e.g., recent Healthy King County Coalition (HKCC) data workshop for community members
3. CCV should be present at every level of ACH structure in order to provide reality checks about relevance and feasibility of ideas prior to decisions and/or implementation
   - ACH ILC workgroups - CCV input via methods matching interest, time commitment level, content familiarity, etc.
   - Workgroup participation
     - Given focus of Data and Sustainability workgroups, community advocates involved in relevant work seem likely to be interested in participating in these workgroups
     - Provide information about workgroup purpose, value add, responsibilities and duration of commitment
     - Provide training support for CCV representatives to participate at decision tables (needs resourcing)
   - Workgroup topic focused "community conversations"
     - Possible method for involving broad and diverse range of individuals/constituents/consumers via partnering with CBOs to host session at appropriate points during the ACH development process
     - High community/consumer interest likely in the Regional Health Improvement Plan and Physical/Behavioral Health Integration
     - Provide financial support for CCV inclusion, e.g.:
       - Funding for CBO-hosted community events,
       - Stipends and/or parking cost reimbursement for CCV workgroup members
       - Look to other funders for support of CCV involvement e.g., NWAF focused on Native initiative)
4. Focus on a few key things and progress is measured and reported

Brief ACH ILC

At the next meeting of the ACH ILC, on July 20, brief members about the outcomes of this discussion, next steps, and intent for the group to continue meeting.

Information Handout Invitation

Prepare informational handout inviting CCV to the Performance Measurement work group and the Regional Health Plan Improvement work group. Use the handout to support invitations for likely work group prospects by August 20.

Next Meeting

- Continue discussion on unfinished topics on 7/20 following ACH ILC meeting; staff will confirm availability of space to meet from 4-5 p.m. and get back to everyone.
- Continue having this group meet as a proposed ad hoc work group of the ACH-ILC as needed; set future meeting date pending discussion at the July ACH ILC meeting

King County Accountable Community of Health

Community Engagement Discussion

July 20, 2015, 4:00 p.m. – 5:00 p.m.

King County Elections Building, 919 SW Grady Way, Renton, WA

Members Present: *Elizabeth "Tizzy" Bennett* (Seattle Children's Hospital), Shelley Cooper-Ashford* (Healthy King County Coalition), Daniel Gross (Northwest Health Law Advocate), Kris Lee* (Amerigroup), and Rebecca Saldaña* (Regional Equity Network)*

*ACH Leadership Council member

Staff:
Gloria Albetta, A.J. McClure, Gena Morgan, and Janna Wilson (Public Health – Seattle & King County)

Facilitation:
Wendy Watanabe (Watanabe Consultation)

MEETING PURPOSE

Discuss proposed ACH ILC Charter changes in order to bring recommend changes to the council at their next meeting.

DISCUSSION HIGHLIGHTS

1. "*Community member*" is defined as: a person impacted by health or health-related inequities.
2. Recommended Charter changes:

Charter Section: PURPOSE

Section 3. Values – ENGAGEMENT OF THOSE MOST AFFECTED

Change the current charter language as follows:

"Putting this value into practice will entail intentional development and resourcing of capacity and mechanisms that support two-way communication so that on-the-ground context expertise is ~~brought to bear~~ ***shall be included*** *in ACH development,* ***governance,*** *decision-making and initiatives."*

~~Add: "Health care consumers and members of the community affected by the ACH's work shall be included in the governance, planning and oversight of the ACH."~~

Rationale: Language change to emphasize value of community members' role and presence in ***shaping*** ACH decisions, not simply providing input

Section 3. Values - ACCOUNTABILITY

Add as a separate bullet point in the list: "Accountable to the individuals in the community who experience health and health- ~~access~~ *related* inequities and who most need and will be impacted by the ACH's work."

Rationale: Specifies accountability to community members impacted by ACH work

Charter Section: MEMBERSHIP AND ROLES

Section 4. Membership - MEMBERSHIP

Add as a separate bullet point in the list: community member(s) impacted by health/health-related inequities - to be invited*

~~populations most in need/affected by the ACH's work, e.g., "Low-Income Community Members," "Health Care Consumers," "Individuals with Chronic Conditions," "Immigrants," "Seniors," individuals with disabilities," and/or "individuals who experience language barriers."~~

Rationale: In keeping with the general categories already listed; more than one needed as sufficient "critical mass" and/or representative of multiple populations

(Criteria such as low income, person of color, representative of population facing multiple barriers should be considered in seeking potential members of the ACH ILC/LC)

Section 5. Functioning of the ACH Leadership Council

~~Add: work group for consumer engagement and create a plan to educate and identify consumers for progressively more responsible participation in ACH governance, planning and oversight activities~~.

Add: Create an ad hoc committee on community voice (ACH ILC members and other interested parties) to foster authentic partnering of community members with the ACH ILC

Rationale: Think through issues and support /sustain community members' participation

Section 5. Functioning of the ACH Leadership Council – STEERING COMMITTEE

Add: The Steering Committee is comprised of 4-**7** leadership council members. This will include one interim leadership council member representative from each of the three workgroups, and up to 4 other members, including **at least one seat for an ILC community member representative, should a representative be interested**.

Rationale: Representation at all levels of the ACH ILC

**While there is limited time remaining for the interim ACH Council and finding representatives may take awhile, it is important to create placeholders in the Charter for community voice at all levels and start recruiting now.*

OTHER RECOMMENDATIONS

- **Use multiple methods to include community perspective (to accommodate interests/time commitments):**
  - **Add community advocate representatives to ACH ILC workgroups. Provide one page informational handout on workgroups to invite potential community representatives**
  - **Elicit broad community member perspectives on ACH work/workgroups via hosted "community conversations" by trusted CBO's.**
- **Provide financial support for community inclusion (e.g. event funding, meeting stipends, etc.)**

NEXT MEETING

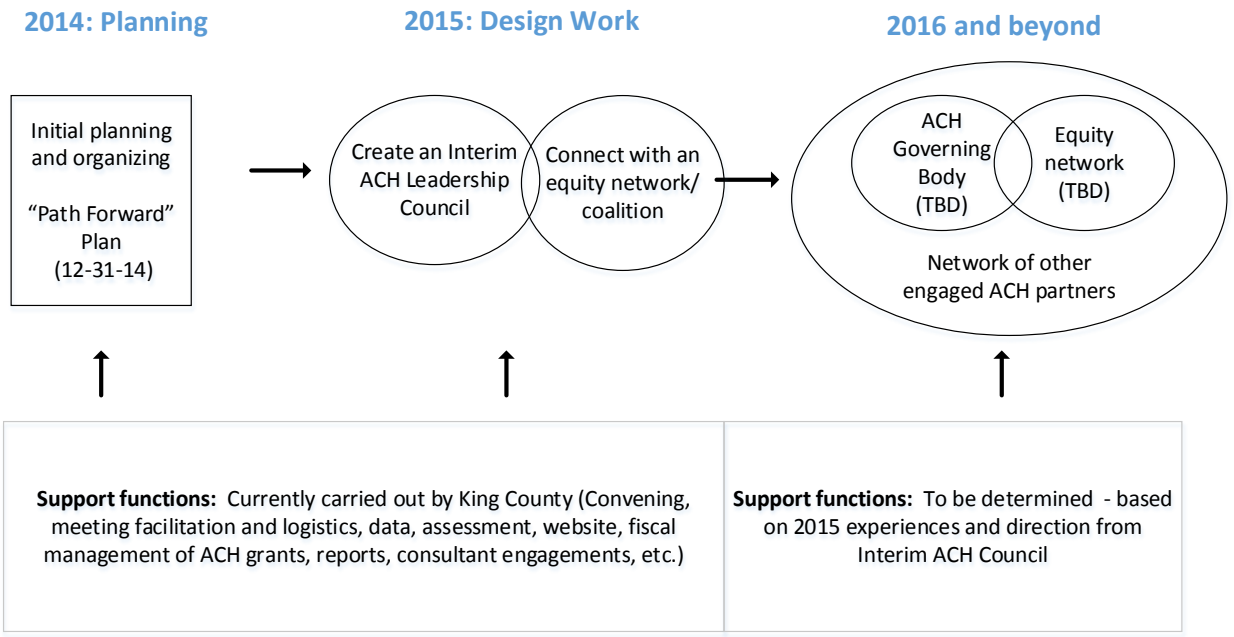
Discuss creating a supportive environment for community member inclusion during August 17 conference call, scheduled for2:00 pm.

BACKBONE FINANCIAL & ADMINISTRATIVE FUNCTIONS

- Visual Representation of Phased Approach to ACH Design
- Overview of ACH Development in the King County Region (August 2015)
- Performance Measurement Work Group – Charter
- Performance Measurement Work Group – Members
- Performance Measurement Work Group Meeting Summaries
    - June 10
    - July 13

Visual Representation of Phased Approach to ACH Development

(Included in application for ACH Design grant, December 2014)



Overview of the King County Region Accountable Community of Health Development

As of August 2015

What's behind the Accountable Community of Health initiative?

In 2014 Washington created an ambitious 5- year plan to improve health and health care. Healthier Washington is a roadmap for transforming health and health care in our state in order to achieve better care for individuals and better health of the population at lower costs. Late in 2014, the state received a five-year, $65 million federal grant to carry out Healthier Washington strategies.

Regional collaboratives are a building block of the plan. To create lasting change in health and in healthcare, local innovation and partnerships are critical because so many factors and sectors influence our health. Clinical care accounts for about 20%, our health behaviors 30%, social and economic factors 40%, and the physical environment 10%.

To help bring clinical and community partners together to carry out high priority health improvement strategies and align their efforts around shared results, the plan calls for the creation of regionally based Accountable Communities of Health (ACHs). The emerging ACHs are engaging many sectors that affect health, such as health care payers and providers, behavioral health, public health, social services, housing and community/economic development, philanthropic organizations, education, health equity and social justice coalitions, and governmental entities, including Tribes.

Nine ACH regions established. Washington identified nine ACH regions that together cover the entire state. King County is a single-county ACH region. The State is partnering with each region to invest in ACH development and proof of concept, building on collaborations already underway. Washington intends to formally "designate" an ACH coalition in each region when they have established a sufficiently strong foundation of governance and administrative infrastructure—interim or otherwise—to move to the next phase of development.

ACH Regions Map

HCA 82-008 (7/15)

How has ACH development evolved in the King County region?

Focused on advancing what the region is already trying to make happen. Many organizations in the King County region are involved in innovative, cross-sector partnerships to improve community health and well-being, because working together can produce better results than working alone – especially for the most complex challenges. Therefore, the King County region has been approaching ACH development as an opportunity to strengthen this infrastructure in order to both catalyze even more innovation and better spread and sustain what works.

Washington's ACH initiative commenced just when the forward-looking *King County Health and Human Services Transformation Plan* was completed with community partners. This plan recognizes that the region's overall high quality of life masks profound disparities in health and well-being. It aims to address those disparities through greater collaboration, better integrated and "whole person" models of care delivery, and prevention-focused strategies that address the upstream, social determinants of health. In this way, the Health and Human Service Transformation Plan is very consistent with the state's Healthier Washington vision.

What was the upshot of the initial 2014 ACH planning phase in King County?

In mid-2014, the Washington Health Care Authority made available grants of up to $50,000 for regions across the state to begin planning for ACH development. Public Health - Seattle & King County, with support from consultants Cedar River Group and Watanabe Consultation, served as the planning phase grantee for the King County region.

Together with stakeholders the following major recommendations[1] were made:

- Partner with and learn from high priority initiatives already underway, including the *King County Health and Human Services Transformation Plan*, to assure "**form follows function**" in ACH development.
- In 2015, don't jump to creating too much infrastructure too fast. Focus on **showing value and progress** relative to existing initiatives.
- Work to resource and promote authentic **community engagement** in subsequent phases of ACH design work; doing so is critical for assuring that ACH activities lead to greater health equity and lasting change.
- Create an **interim ACH leadership council** in 2015 to guide the next phase of development, and charge it with developing and transitioning to a more formalized governance structure.

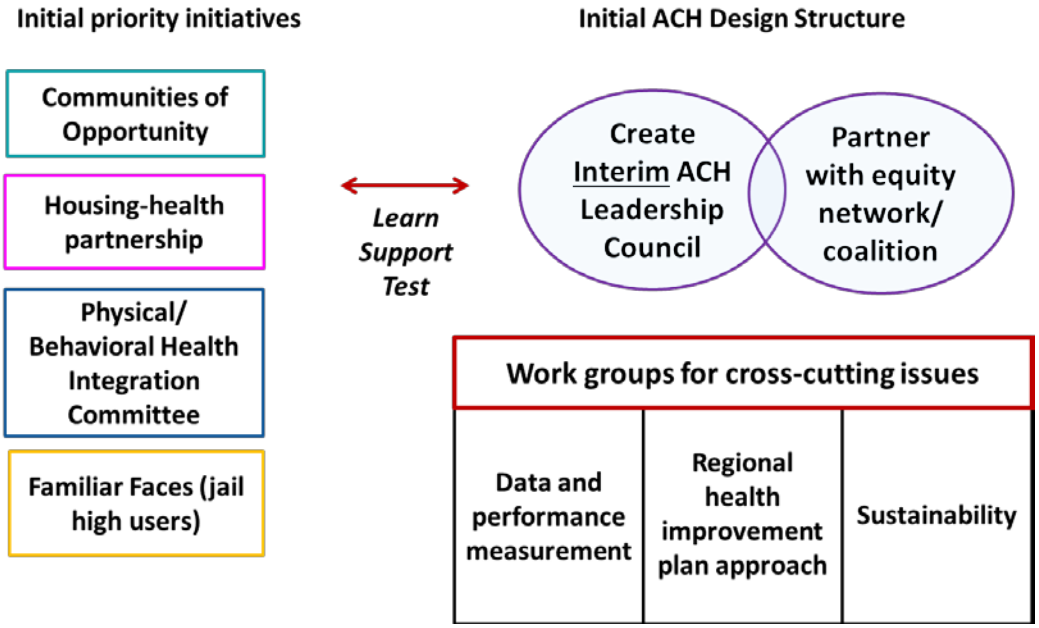
At the end of the planning phase, Public Health received a $100,000 design grant from the Washington Health Care Authority to convene and support the ACH interim leadership council in 2015. Many partners are bringing in-kind time and other forms of support to the work, as well.

[1] The planning phase report, *A Path Forward for ACH Design in King County, Washington (December 2014)*, is available at http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach.aspx.

How is the 2015 ACH design work organized?

The graphic below shows the structure of the ACH design work for the King County region.

- On the left are four existing high priority initiatives in different stages of development. The ACH leadership council and its workgroups will support them moving forward, as appropriate, and learn from them to inform ACH structure and governance.
- Another critical piece of the design strategy is to partner with and build capacity in equity networks/coalitions because community engagement mechanisms will bring on-the-ground context expertise into ACH design, decision-making, and implementation.
- Cross-cutting work groups will support both the four existing initiatives, as well as make recommendations about the longer-term structures the ACH partnership will need and how to organize to accomplish them.



Learn more about the four initiatives:

Communities of Opportunity – is working to create greater health, social, economic, and racial equity in specific geographic areas of King County where disparities are the greatest.

Housing-health partnership planning - seeks to develop a sustainable business model for improving the health of multi-family affordable housing residents and surrounding neighborhoods by using affordable housing as platform for housing-health partnerships.

Physical/Behavioral Health Integration – will be designing a model to move toward fully integrated care and financing across physical and behavioral health, focused on Medicaid recipients.

Familiar Faces – intends to improve outcomes in health, housing, and justice system involvement while reducing per capita costs. Focuses on adults who are high users of the King County jail who have a mental health and/or substance abuse condition.

What is the role of the King County ACH Interim Leadership Council?

The ACH Interim Leadership Council is guiding the next phase of the ACH development in King County. Information about its members and meetings is available on the King County ACH website. Meetings are open to the public. In June, members agreed on a charter to guide its work.

The Interim Leadership Council will develop structures that will enable cross-sector health improvement efforts to be as successful and sustainable as possible. Members will explore strategies for future sustainability, an approach to a future regional health improvement plan, and how best to align with Healthier Washington's statewide common performance measures and with other ACHs across the state.

The ACH is in its early, formative stages. State and community partners will continue to come together to plan, implement, measure, and adjust strategies in the months and years to come. The Interim Leadership Council welcomes comments from interested parties, either at its meetings or by writing to hhstransformation@kingcounty.gov.

Key deliverables in 2015 will include: An ACH Readiness Proposal to submit to the Washington Health Care Authority for ACH designation; an approach to a future regional health improvement plan, an approach to sustainability planning, and an approach to governance and administrative functions that includes ongoing processes for making adjustments as the environment changes.

Staying Informed and Getting Involved

- Sign up for stakeholder e-mail distribution list by writing to: hhstransformation@kingcounty.gov
- Visit the King County ACH website – still a work in progress, you'll find more resources posted here over time as work moves forward: http://www.kingcounty.gov/exec/HHStransformation/ach.aspx
- Visit the Healthier Washington ACH website: http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx
- King County region ACH contacts: Gena Morgan at gena.morgan@kingcounty.gov or Janna Wilson janna.wilson@kingcounty.gov

This project is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

CHARTER
ACH Performance Measurement Workgroup

PURPOSE

- **Background**

The King County Accountable Community of Health (ACH) aims to "build healthier communities through a collaborative regional approach focusing on social determinants of health, clinical-community linkages, and whole person care". Embodied in this mission is an awareness that to achieve the Triple Aim of better health, better quality, and lower costs, we must increasingly focus on prevention and seek solutions both within and outside of the health care delivery system. Due to the complex nature of the upstream social drivers of health (i.e. where we live, work, and play), cross sector, cross agency and cross community strategies are essential in order to achieve the Triple Aim.

Not surprisingly, the same is true for information – cross sector, cross agency, and cross community sharing of data is required for rigorous and full assessment of the health and social needs of individuals and their communities, prioritization of strategies, and measurement of progress towards the Triple Aim and equity. No one organization can sustainably improve health or fully measure progress while working alone.

To address the current state of data fragmentation within King County, and the need for alignment with the state and other ACHs, the King County ACH interim Leadership Council formed the Performance Measurement Workgroup (PMW), one of three ACH workgroups designed to address "cross-cutting" roles of the ACH (and meet deliverables laid out in the Health Care Authority Design contract).

- **Purpose**

The purpose of the PMW is to provide an initial set of recommendations to the ACH Leadership Council and support the data and evaluation needs of cross-sector health improvement initiatives and the overall ACH. With the ACH model, there is a clear intent to regionalize certain aspects of assessment, evaluation, and purchasing of health care contracts. To support this regional role, the King County ACH should assure coordination with the state's investments in Analytics, Interoperability, and Measurement (AIM) made through *Healthier Washington*, as well as the work of other ACHs. The aim is to avoid duplication and ensure access to shared data assets so that the King County ACH and its local initiatives can assess needs, prioritize strategies, and evaluate progress in a timely and accurate manner.

- **Accountability**

The PMW will be accountable to and seek guidance from the ACH Leadership Council as it develops its initial set of recommendations. Specifically, the PMW co-leads will attend interim ACH Leadership Council meetings to present updates and request feedback on key issues. Additionally, the PMW will request support as needed to resolve data barriers for the four linked initiatives.

- **Core Principles**

Adapted from the five core conditions of collective impact and the King County ACH planning process, the following core principles express important, shared beliefs of the PMW and will guide its behaviors and decision-making over the course of the year.

- **Backbone function.** In this initial phase of building shared data, leverage dedicated staff with specified skills to accelerate cross sector and cross agency data sharing. Build on data systems and structures that are already in place. Ensure a sufficient level of administrative and operational support to move the PMW agenda forward.
- **Shared data/measurement.** Shared data is needed to understand the whole picture of an individual or community. When data is shared across stakeholder groups, everyone benefits.
- **Common agenda.** Build a common vision for shared and integrated data in King County. Align with state and other ACHs to avoid duplication and promote consistency across data systems.
- **Mutually reinforcing activities.** Consider both qualitative (community-sourced) and quantitative (organization-sourced) information when building shared data. No one organization holds the data necessary to evaluate the full Triple Aim for all communities.
- **Continuous communication & phased approach.** Demonstrate early successes and use learning and rapid feedback to continually readjust approach. Under the guidance of the ACH Leadership Council, ensure that both the PMW membership and scope of work remain flexible to adapt to changing needs and partnerships over time.
- **Equity**. In all decisions, consider whether equity is being prioritized. Assess whether groups have had an opportunity to be represented in our data systems, as well as an opportunity to opt out of shared data. Ask whether our data systems are enabling King County to measure progress towards equity and social justice.

MEMBERSHIP AND ROLES

- **Membership**

Key members will include sectors represented on the ACH Leadership Council (e.g. managed care organizations), King County agencies, and technical experts. The PMW will also draw in state partners from the WA Department of Social and Human Services (DSHS), the WA Health Care Authority (HCA), and the WA Department of Health (DOH) to support alignment with state priorities and data investments.

This membership represents an initial phase of building shared data in King County relative to the four "linked initiatives", and we expect that the PMW composition and its work will evolve over time.

Initial Membership. The PMW will initially comprise representatives from the following sectors/entities.

- *Public Health-Seattle & King County (PHSKC) Chief of Assessment, Policy Development and Evaluation
- *Member of the ACH interim Leadership Council – managed care organization (MCO) member of ACH interim Leadership Council, to rotate through 5 MCOs on a quarterly basis
- King County government leaders and staff involved in data sharing and use (Department of Community and Human Services) and PHSKC privacy officers; King County Information Technology; DCHS medical director and PHSKC health officer; and DCHS analyst
- Health economist
- State agency partners: Department of Health; Department of Social and Health Services; Health Care Authority
- Others as appropriate, as the work evolves

* Co-leads

In addition to the membership, there will be a technical lead (PHSKC analyst) to provide staffing for the PMW.

- **Participation**

A monthly meeting series for the PMW has been established. The PMW may decide to add, cancel, or modify meetings as appropriate throughout the year.

The PMW technical lead will prepare objectives and materials for each meeting. Agenda and meeting materials will be distributed at least three business days in advance. The PMW technical lead will co-facilitate meetings with the PMW co-leads.

Additionally, a project staff member (PHSKC social research scientist) will attend all PMW meetings to represent PHSKC and DCHS's 2-year, grant-funded evaluation of building shared data in the ACH context. This project staff member will record and distribute meeting summaries to the PMW membership, and collect as well as rapidly share back information to identify issues and opportunities as they unfold over the course of this innovative work.

SCOPE AND DELIVERABLES

The initial scope of the PMW will include providing recommendations to the ACH Leadership Council and supporting data and evaluation needs of the linked initiatives. To this end, the PMW will:

- Identify components for building shared data in King County
- Develop a value proposition for shared data
- Explore alignment with other ACHs and the state around metrics, access to data, and interoperability
- As appropriate, support data needs of King County cross sector initiatives
- Recommend future role, home and structure of PMW in 2016

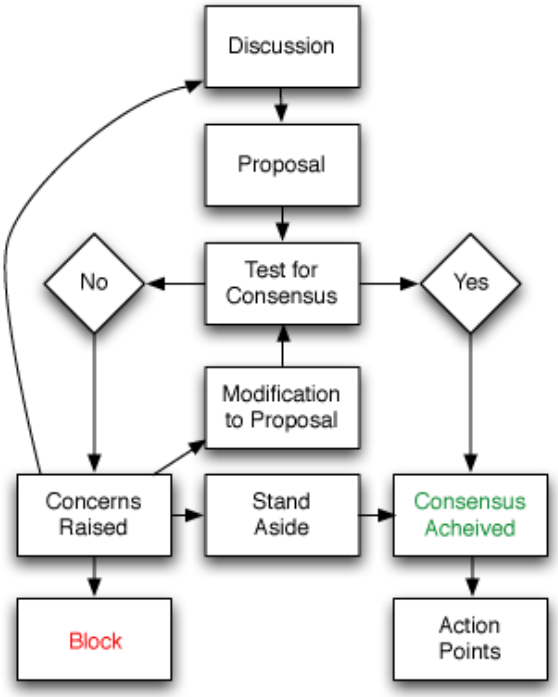
Through this work, the PMW will produce the following deliverables:

- Summary of required elements and value proposition for data sharing in King County
- Recommended approach for alignment with other ACHs and the state around metrics, access to data, and interoperability
- A proposed future role, home and structure of the PMW in 2016
- Final report to the ACH Leadership Council summarizing the above work

DECISION MAKING

- **Decision Making Approach**

Because achieving voluntary agreement and building trust among different partners is essential for building shared data in any environment, the PMW will make decisions and recommendations by consensus. This approach encourages putting the good of the whole above the interests of a single person/organization, and finding solutions that all parties support or at least can live with. Decisions will be documented in meeting summaries. The figure on the right outlines the process steps in consensus decision making.[1]



Levels of agreement:

- I can say an unqualified "yes."
- I can accept the decision.
- I can live with the decision.
- I do not fully agree with the decision, however, I will not block it.
- I cannot live with the decision and will block it.

The PMW aims to reach decisions by full consensus. The PMW will work to understand and integrate perspectives of all members until an agreeable solution can be found in a reasonable amount of time. Consensus may not mean 100% agreement on all parts of an issue, but rather that all members have reviewed a decision and are fully supportive, can accept the decision, can live with the decision, or do not fully agree, but will not block a decision. In the event that consensus is not possible, the PMW can invoke “consensus-minus-one” and move forward with a decision or proposal with a maximum of one member not supporting the decision.

Key decisions will be made in person at PMW meetings. Members will be provided with adequate advance notice about decision items. The PMW will attempt to reach consensus and if accomplished, this decision will be communicated by email to all absent PMW members, who will have 4 business days to submit their level of agreement to the PMW technical lead. If a member’s response is not received by the end of the 4th business day, this implies consent on the behalf of this member. For more routine items, decision making may be conducted over email and/or phone.

[1] "Consensus-flowchart" by grant horwood, aka frymaster - http://en.wikipedia.org/wiki/Image:Consensus-flowchart.png. Licensed under CC BY-SA 3.0 via Wikimedia Commons - http://commons.wikimedia.org/wiki/File:Consensus-flowchart.png#/media/File:Consensus-flowchart.png

NAME AND AFFILIATION	WORKGROUP ROLE
Mary Jane Alexander Privacy Officer Public Health, Seattle & King County	Data sharing must protect individual confidentiality and follow regulations
Jeff Duchin Health Officer Public Health, Seattle & King County	Perspective on individual- and population-level use of health and human services data
Rene Franzen Privacy Officer Community & Human Services, King County	Data sharing must protect individual confidentiality and follow regulations
Tracy Hilliard Director of Data Integrity City of Seattle	The City of Seattle is a key partner in transformation initiatives and has a role in administering HMIS
Jutta Joesch Health Care Economist Executive's Office, King County	Reducing health care costs is one element of the Triple Aim
Kathy Lofy State Health Officer Department of Health, WA	Promote alignment with Analytics, Interoperability & Measurement work of Healthier Washington
David Mancuso Director, Research & Data Analysis Division Department Social & Health Services, WA	Promote alignment with Analytics, Interoperability & Measurement work of Healthier Washington
Diep Nguyen IT Service Delivery Manager, Information Technology, King County	Shared and integrated data requires IT infrastructure
Laura Pennington Performance Measures Program Manager Office of Health Innovation & Reform Health Care Authority, WA	Promote alignment with Analytics, Interoperability & Measurement work of Healthier Washington
Marguerite Ro, Co-Lead CDIP Chief, APDE Chief Public Health, Seattle & King County	DCHS and PHSKC are two primary providers of health & human services information
Caitlin Safford, Co-Lead Manager, External Relations Coordinated Care	Critical link with the Leadership Council, to which the PMW is accountable
Debra Srebnik Analyst, MHCADSD Community & Human Services, King County	DCHS and PHSKC are two primary providers of health and human services information
Brent Veenstra IT Manager Information Technology, King County	Shared and integrated data requires IT infrastructure
Maria Yang Medical Director Community & Human Services, King County	Perspective on individual- and population-level use of health and human services data
Lee Thornhill, Interim Technical Lead Social Research Scientist, APDE, Public Health, Seattle & King County	To serve as technical lead for the PMW

NOTES

King County ACH Performance Measurement Workgroup (PMW)

Meeting 1: June 10, 2015 9:00-10:30am

ATTENDANCE

In person: Deb Srebnik (DCHS), Janna Wilson (PH), Susan Mclaughlin (DCHS), Brent Veenstra (KCIT), Jeff Duchin (PH), Rene Franzen (DCHS), Jutta Joesch (KC), Diep Nguyen (KCIT), Mary Jane Alexander (PH), Lee Thornhill (PH), Eli Kern (PH), Marguerite Ro (PH), Maria Yang (DCHS)
Phone: Laurel Lee (Molina); Cathy Wasserman (DOH), Anna Simon (CHPW), Chase Napier (HCA)

KEY DECISIONS

- *Charter:* agreement that it was needed and initial draft was acceptable with detailed edits outlined below.
- *Right Now Survey*: will pilot test a modified version to gather rapid feedback at next meeting.

ACTION ITEMS/TO DO – LEE & ELI

- *Resource Guide*: steps, key information for data sharing (to be evolving, working document).
- *Diagram*: with elements that are key to shared data (i.e. DSAs, laws/regs, technical safeguards, end user access, uses of data). Add this as another activity/deliverable tied to resource guide.
- *Glossary:* (e.g. community-sourced data, shared data, integrated data, open data). This should accompany charter.
  Charter Edits:
  - p. 1: Purpose section, first sentence, change to "and" support the data and evaluation Core principles: Edit 'build shared vision for shared and/or integrated data'
  - Include scope & deliverables in charter.

CLARIFICATIONS

- Deb. S is on – as DCHS/PHSKC analyst member

TECHNICAL ISSUES

Some callers dropped off at 10:02am. It was unclear who we lost during the call back. We need to remind participants about putting a call on hold (i.e music may play during interim)

TABLED TO NEXT/FUTURE MEETING

- *Decision Making Process*
- Potential Reach Beyond ACH – discuss how this work can impact/extend beyond just ACH initiatives

JULY 13TH NOTES

King County ACH Performance Measurement Workgroup

July 13th 2015 3:00-4:30pm

Attendance: Marguerite Ro (PH); Caitlin Safford (CC); Janna Wilson (PH); Lee Thornhill (PH); Kevin Meadows (HCA); Maria Yang (DCHS); Amina Suchoski (UHC); Mary Jane Alexander (PH)

1. CLARIFICATIONS TO NOTES/DOCUMENTS

- Minutes from June 10th meeting: approved
- Scope of Work: one edit – change identify "requirements" to "components" for building shared data. This is more reflective of requested work products during first meeting (glossary, diagram, system mapping).
- Charter: approved given change to Scope of Work reflected above is made.

2. MAIN DISCUSSION

Decision Making Process: group discussion of adopting decision making process similar to the King County ACH Interim Leadership Council (ILC). Marguerite presented rationale. Janna and Caitlin gave additional context for how the process is currently working. This included sharing representation by role.

Group discussed how to adapt the process for the PMWG and follow the intention of the ILC process (i.e. participatory and no one sector is dominant).

- *Final decision*: adopt the same decision making process as the ILC. Utilize a "Thumbs up, Middle, Thumbs Down" approach. Utilize any "Thumbs Down" as an opportunity to engage in deeper dialogue and capture in notes. Marguerite or Caitlin will review this process at the next meeting and discuss procedures for voting/communication via e-mail and role sharing (may translate to departments v. sectors for PMWG)

3. PRESENTATION

Kevin Meadows, Project Manager for *Healthier Washington*, provided an impromptu status update on the AIM work so the PMWG could hear similar updates as provided to the ILC on July 7th:

High-level summary points:

- Given that the AIM work is such a big effort, HCA thought it would be best to bring in a firm (Gartner) with experience building HIE/HIT infrastructure from scratch;
- There was a Kick-off meeting in early July with early key stakeholders invested in AIM investments – including HCA, DSHS, and Providence Health;
- Gartner's scope will include examining HCA's current resources, its current needs, and recommend tools/procurement strategies for making its AIM goals a reality;

- Still in the process of assembling the full AIM team. This includes filling the AIM Director role.
- Kevin, and other representatives from HCA, will continue to engage with the PMW, and broader ACH work, as appropriate. Engagement and collaboration remains key.
- Kevin also walked the PMWG through a draft image of the "State Data Lake" for additional context.

4. ANNOUCEMENTS/OPPORTUNITIES

a. Funding Opportunity: RWJF Data Across Sectors of Health (DASH)

Marguerite presented an overview of a new RWJ funding stream that may be connected to the ACH & PMWG. A number of representatives will view the funding webinar on 7/13. Marguerite and Janna will participate in discussing ideas given ACH ILC charter direction to "Facilitate decision-making about how to respond to new cross-sector health improvement initiatives/opportunities should they arise in 2015."

The funding announcement was also circulated widely to elicit additional ideas/new thinking.

b. PWM Presentation to ILC on 7/20

Marguerite and Caitlin will provide a high level overview of PMWG including workplan, membership and about the DASH funding opportunity.

3. KEY DECISIONS

- Tracy Hilliard, Director of Data Integrity, City of Seattle, Human Services Department recommended for membership
- Revised Charter and Workplan approved
- Decision Making Process aligned with ILC approved

4. TECHNICAL ISSUES

No virtual/teleconference participants today.

5. ACTION ITEMS/TO DO

- Marguerite will engage Tracy Hilliard to join PMWG: *complete*
- Marguerite and Caitlin will connect via phone on PMWG presentation to ILC on 7/20: *complete*
- Lee will prepare technical resource draft documents from first meeting (glossary, resource guide, inventories compiled to date): *complete*
- Lee will follow-up on shared document site for PMWG and monitor version control/track document changes: *complete*

Next Meeting: Monday, August 19th at 9:00am-10:30am PH Chinook Building, Room 1113
Conference Call: 206.263.8114; Conference ID: 9078938

Regional Health Needs Inventory and Initial Priorities

- Summary – King County Community Health Needs Assessment 2015-16, King County Hospitals for a Healthier Community
- King County Board of Health Resolution 15-06
- Charter for Regional Health Improvement Plan Work Group
- Regional Health Improvement Plan Work Group Roster
- Regional Health Improvement Plan Work Group Meeting Summary
    - July 23
- Draft Inventory and Themes of Major Assessments in King County (Regional Health Needs Inventory)

King County Community Health Needs Assessment

2015/2016






King County Hospitals for a Healthier Community

Contents

Acknowledgements

Public Health - Seattle & King County
Gloria Albetta, Louise Carter, Meagan Kay , Eli Kern, Susan Kinne, Anna Markee, Molly McNees, Meaghan Munn, Mike Smyser, Lin Song, David Solet, Marguerite Ro, and Eva Wong

EvergreenHealth
Trisha West

CHI Franciscan Health
Kathy Schmidt

St. Elizabeth Hospital
St. Francis Hospital
Highline Medical Center
Regional Hospital

Group Health Cooperative
Theresa Tamura and Carol Cahill

MultiCare Health System
Lois Bernstein and Jamilia Sherls

Auburn Medical Center

Navos
Chris Martin

Overlake Medical Center
Amy McGann

Seattle Cancer Care Alliance
Linda Gainer

Seattle Children's Hospital
Elizabeth Bennett and Victoria Garcia

Snoqualmie Valley Hospital District
Joe Larson

Swedish Medical Center
Tom Gibbon

Ballard Campus
Cherry Hill Campus
First Hill Campus
Issaquah Campus

UW Medicine
Elise Chayet

Harborview Medical Center
Northwest Hospital & Medical Center
UW Medical Center
Valley Medical Center

Virginia Mason
Ingrid Ougland Sellie

Washington State Hospital Association
Chelene Whiteaker

Special thanks to Bill Johnson for page design.

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Pg. 69, Virginia Mason.
Pg.107, MultiCare Health System.
Pg. 113, Seattle Children's Hospital.

Acknowledgements

Continued

We also wish to thank those who provided input to this report:

Aging & Disability Services

Airlift Northwest

AMR Ambulance

Asian Counseling and Referral Services

Behavioral Health Partnership Group

Brain Injury Alliance

Burien Police Department

CarSafe Kids

Catholic Community Services

Cedar River Group

Center for Human Services

Center for Multicultural Health

Central Region EMS & Trauma Care Council

Childhood Obesity Prevention Coalition

Children's Alliance

City of Bellevue

City of Kirkland

City of Lake Forest Park

City of Redmond

City of Shoreline Human Services

Community Health Network of Washington

Community House Mental Health

Community Psychiatric Clinic

Consejo Counseling

Country Doctor Community Health Center

DESC

Duvall Fire Department

Eastside Aid Community

Eastside Human Services Forum

Equal Start Community Coalition

EvergreenHealth Emergency Department

Falck Northwest Emergency Medical Services

Feet First Pedestrian Safety Coalition

Forefront

Friends of Youth

Group Health Emergency Department

Harborview Medical Center Emergency Department

Harborview Mental Health

Harborview Spine Center and Concussion Program

Health Coalition for Children and Youth

Highline Medical Center Emergency Department

Hopelink

Issaquah Human Services Commission

Issaquah Police Department

Issaquah Sammamish Interfaith Coalition

Kent Police Department

King County Council

King County Mental Health Chemical Abuse and Dependency Services

King County Traffic Safety Task Force

Kirkland City Council

Kirkland Police Department

Local Hazardous Waste Management

Maple Valley Police Department

Molina Healthcare

Multicare Auburn Emergency Department

Native American Women's Dialogue on Infant Mortality

NAVOS

Acknowledgements

Continued

Neighborhood House

Newcastle Police Department

Nick of Time Foundation

North Urban Human Services Alliance

Northshore/Shoreline Community Network

Northwest Health Law Advocates

Northwest Hospital Emergency Department

Odessa Brown Children's Clinic

Olympic Physical Therapy

Open Arms Perinatal Services

Overlake Medical Center

Overlake Medical Center Emergency Department

Partners for our Children

Project Access Northwest

Public Health - Seattle & King County:
Alan Abe, Carol Allen, Jennifer DeYoung, Tony Gomez, Scott Neal, Lisa Podell, Whitney Taylor, Crystal Tetrick, Sharon Toquinto, Jim Vollendroff, Emergency Medical Services

Redmond City Council

Redmond Police Department

Renton Police Department

Safe Kids Eastside

Safe Kids Seattle/South King County

SeaMar Community Health Center

Seatac Police Department

Seattle Children's Hospital

Seattle Children's Hospital Emergency Department

Seattle Counseling Service

Seattle Human Services Coalition

Service Employees International Union Healthcare 1199NW

Shoreline Community College

Snoqualmie Valley Hospital Emergency Department

Sound Mental Health

South King Council of Human Services

St. Elizabeth Hospital Emergency Department

St. Francis Emergency Department

The Arc of King County

Tri-Med Ambulance

Valley Cities Counseling

Valley Medical Center Emergency Department

Washington Ambulance Association

Washington Chapter, American Academy of Pediatrics

Washington Dental Service Foundation

Washington State Department of Health

Washington State Hospital Association

WithinReach

YMCA

Youth Eastside Services

YWCA Seattle-King-Snohomish

Summary

King County Community Health Needs Assessment 2015/2016

King County Hospitals for a Healthier Community (HHC) is a collaborative of all 12 hospitals and health systems in King County and Public Health-Seattle & King County. For this report, HHC members joined forces to *identify important health needs and assets in the communities they serve.* HHC members have also worked together to increase access to healthy foods and beverages in their facilities and to address access-to-care issues by assisting with enrollment of residents in free or low-cost health insurance.

This Community Health Needs Assessment (CHNA) is an HHC collaborative product that fulfills Section 9007 of the Affordable Care Act. The report presents data on:

- **Description of Community:** In an increasingly diverse population of 2 million, large health inequities persist. Rates of poverty and homelessness continue to rise.
- **Life Expectancy and Leading Causes of Death:** Life expectancy in King County neighborhoods can vary by up to 10 years. Leading causes of death among older adults are cancer and heart disease, while injuries are the leading causes of death among children, teens, and young adults.
- **Chronic Illness:** Disparities in chronic illness by race/ethnicity, poverty, and neighborhood are considerable. Asthma and diabetes are common in adults and children. The leading causes of hospitalizations (after pregnancy/childbirth) are heart disease, injury, mental illness, and cancer.

"Hospitals are 'cornerstone institutions'; they are major forces in the community and should work to improve conditions. They have influence."

– King County physician

Summary

Continued

Community Input

We invited community coalitions and organizations to tell us about the assets and resources that help their communities thrive. The assets most frequently mentioned were existing partnerships and coalitions, community health centers, faith communities, and food programs.

We also asked community representatives to identify concerns about health needs in their communities. Common themes included:

1) the importance of a culturally competent workforce in addressing health disparities;

2) acknowledgement that health is determined by the circumstances in which people are born, grow up, live, work, and age, which are in turn shaped by a broad set of forces;

3) the need for hospitals to engage with communities and develop authentic partnerships; and

4) the influential role of hospitals as anchor institutions in addressing social, economic, and behavioral factors.

Identified Health Needs, Assets, Resources, and Opportunities

The report integrates data on HHC's identified health needs with input from community organizations about assets, resources, and opportunities related to those needs:

- **Access to Care:** Lack of health insurance is common among young adults, people of color, and low-income populations. For 1 in 7 adults, costs are a barrier to seeking medical care. Opportunities include providing assistance to the uninsured or underinsured, addressing issues of workforce capacity and cultural competency, ensuring receipt of recommended clinical preventive services, supporting non-clinical services, and increasing reimbursement for oral health care.

- **Behavioral Health:** Access to behavioral healthcare, integration of behavioral and physical healthcare, and boarding of mental health patients were identified as key issues. Opportunities include use of standardized referral protocols, coordinated discharge planning, and increased capacity for integrated healthcare.

Summary

Continued

- **Maternal and Child Health:** Disparities in adverse birth outcomes persist, and the percentage of births in which mothers obtained early and adequate prenatal care is too low. Community-based organizations stress the importance of baby-friendly hospitals, quality prenatal care, and ongoing social support, as offered by home visiting programs.
- **Preventable Causes of Death** include obesity, tobacco use, and lack of appropriate nutrition and physical activity. More than half of adults and 1 in 5 teens are overweight or obese, so increasing access to healthy food and physical activity is critical. In the face of declining resources for tobacco prevention/cessation and persistent disparities in tobacco use, evidence-based opportunities include anti-tobacco messaging and brief clinical tobacco screening.
- **Violence and Injury Prevention:** Deaths due to falls and suicide are both rising; and distracted/impaired driving concerns both community members and law-enforcement officials. Opportunities include regional coordination and standard implementation of best practices in violence injury and prevention (including prevention-related primary care assessment/screening).

The HHC collaborative and individual hospitals and health systems already partner or are interested in partnering with community coalitions and organizations in implementing strategies informed by this assessment and other tools. Working together, hospitals and health systems, public health, and communities can reduce healthcare costs and improve the health of all people in King County.

King County

KING COUNTY

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Signature Report

May 22, 2015

Resolution 15-06

Proposed No. 15-06.1 **Sponsors**

A RESOLUTION supporting ongoing collaboration to assess the health needs and assets of King County communities and the development of strategies to improve community health.

WHEREAS, King County is home to many of the country's preeminent hospital systems that in addition to providing safe and high quality care have a long history of addressing our community's health through community benefit programs, and

WHEREAS, community benefits are programs or activities that promote health and healing as a response to identified community needs. Examples of community benefits include charity or unreimbursed medical care, community health education, training and continuing medical education for community physicians, medical research, disease and violence prevention programs and community-building activities that promote health such as physical and environmental improvements, workforce development and coalition building, and

WHEREAS, the Affordable Care Act established guidelines for the process by which hospitals should assess the health needs of their communities to inform their community benefit activities, and

WHEREAS, twelve hospital systems in King County came together with each other, the Washington State Hospital Association and Public Health - Seattle & King

County in 2011 to form a collaborative partnership called King County Hospitals for a Healthier Community, and

WHEREAS, King County Hospitals for a Healthier Community recognizes that by working together the partners can better leverage expertise and resources to address the most critical health needs in our county and avoid duplication, and

WHEREAS, under the Affordable Care Act, nonprofit hospitals are expected to complete a community health needs assessment every three years and use the results to inform implementation strategies to meet identified community health needs, and

WHEREAS, as one of the first collaborations of King County Hospitals for a Healthier Community, the partners joined forces to develop a collective community health needs assessment and issued it in March 2015, and

WHEREAS, the community health needs assessment reports the demographics of King County and data on life expectancy and leading causes of death and chronic illnesses, and

WHEREAS, the community health needs assessment identified the health needs of the community to include access to care, behavioral health, maternal and child health, preventable causes of disease and violence and injury prevention, and

WHEREAS, the community health needs assessment highlighted issues important to the community. Common themes included: the importance of addressing basic needs like housing and transportation; reducing health inequities; increasing cultural competency and continuing to improve health insurance coverage, health literacy and healthcare system navigation; and strengthening community input and inclusiveness and recognizing existing community assets and resources, and

WHEREAS, Washington state is working to drive improved health for populations and communities through the Healthier Washington innovation plan, and

WHEREAS, Healthier Washington includes a strategy to build healthier communities through collaborative, regionally-governed structures called Accountable Communities of Health, and

WHEREAS, members of King County Hospitals for a Healthier Community are currently engaged in Accountable Community of Health initial design activities in the King County region including participation in the interim Accountable Community of Health Leadership Council, and

WHEREAS, the future King County Accountable Community of Health will be expected to develop a regional health improvement plan that will help focus and align priority health improvement strategies in the region;

NOW, THEREFORE, BE IT RESOLVED by the Board of Health of King County:

A. The Board of Health commends King County hospitals and health systems, the Washington State Hospital Association and Public Health-Seattle & King County on the issuance of its first joint community health needs assessment.

B. The Board of Health urges King County Hospitals for a Healthier Community to use of the results of the community health needs assessment to inform their individual and collective community benefit strategies.

C. The Board of Health encourages the Accountable Community of Health Interim Leadership Council to consider, leverage, and build upon the community health

needs assessment as it considers its approach to developing a future regional health improvement plan.

Resolution 15-06 was introduced on and passed by the Board of Health on 5/21/2015, by the following vote:

Yes: 8 - Mr. McDermott, Ms. Wales, Mr. Dembowski, Dr. Delecki, Ms. Honda and Mr. Okamoto
No: 0
Excused: 5 - Ms. Lambert, Mr. Licata, Mr. Baker, Dr. Danielson and Ms. Sawant

BOARD OF HEALTH
KING COUNTY, WASHINGTON

Joe McDermott, Chair

ATTEST:

Melani Pedroza for

Anne Noris, Clerk of the Board

Attachments: None

CHARTER

ACH Regional Health Improvement Plan Work Group

PURPOSE

- **Background**

The King County Accountable Community of Health (ACH) aims to "build healthier communities through a collaborative regional approach focusing on social determinants of health, clinical-community linkages, and whole person care". Embodied in this mission is an awareness that to achieve the Triple Aim of better health, better quality, and lower costs, we must increasingly focus on prevention and seek solutions both within and outside of the health care delivery system. Due to the complex nature of the upstream social drivers of health (i.e. where we live, work, and play), cross sector, cross agency and cross community strategies are essential in order to achieve the Triple Aim.

Not surprisingly, the same is true for assessment and planning – cross sector, cross agency, and cross community sharing of data is required for rigorous and full assessment of the health and social needs of individuals and their communities, prioritization of strategies, and measurement of progress towards the Triple Aim and equity. No one organization can sustainably improve health or fully measure progress while working alone.

To inventory the existing regional assessment processes, plans, and priorities across King County, make recommendations for next steps toward a regional health improvement plan, and address the need for alignment with the state and other ACHs, the King County ACH interim Leadership Council formed the Regional Health Improvement Plan Work Group (RHIPW), one of three ACH work groups designed to address "cross-cutting" roles of the ACH (and meet deliverables laid out in the Health Care Authority Design contract).

- **Purpose**

The purpose of the RHIPW is to provide recommendations to the ACH Leadership Council to support the development of a Regional Health Improvement Plan. Specifically, no later than the end of 2015, the RHIPW will create a Regional Health Needs Inventory (RHNI) and an approach to the development of a Regional Health Improvement Plan (RHIP). The work group will also develop a proposal for the role, home, and structure for the RHIPW in 2016 and beyond. This effort is intended to leverage existing resources at a community and regional level to avoid duplication of effort. It will be important to reach beyond traditional health partners to achieve our objectives.

- **Accountability**

The RHIPW will be accountable to and seek guidance from the ACH Interim Leadership Council as it develops its initial set of recommendations. Specifically, the RHIPW co-leads will attend interim ACH Interim Leadership Council meetings to present updates and request feedback on key issues.

- **Core Principles**

Adapted from the five core conditions of collective impact and the King County ACH planning process, the following core principles express important, shared beliefs of the RHIPW and will guide its behaviors and decision-making over the course of the year.

- **Backbone function.** In this initial phase of developing a RHNI and approach to a RHIPW, leverage dedicated staff with specified skills to accelerate cross sector and cross agency planning. Build on assessments, plans, and processes that are already in place. Ensure a sufficient level of administrative and operational support to move the RHIPW agenda forward.
- **Shared data/measurement.** Shared data and information is needed to understand the whole picture of an individual or community. When data is shared across stakeholder groups, everyone benefits.
- **Common agenda.** Build a common vision for the development of a Regional Health Improvement Plan in King County. Align with State priorities as much as possible.
- **Mutually reinforcing activities.** Consider both qualitative (community-sourced) and quantitative (organization-sourced) information when developing the RHIPW. No one organization holds the data necessary to evaluate the full Triple Aim for all communities.
- **Community Voice.** Consider the point of view and desires of the communities in King County that have the greatest disparities in health indicators and indicators of the social determinants of health through such connections as Communities of Opportunity, Familiar Faces and the Equity Network.
- **Continuous communication & phased approach.** Demonstrate early successes and use learning and rapid feedback to continually readjust approach. Under the guidance of the ACH Leadership Council, ensure that both the RHIPW membership and scope of work remain flexible to adapt to changing needs and partnerships over time.
- **Equity**. In all decisions, consider whether equity is being prioritized. Assess whether community voices have had an opportunity to be represented in our inventory and planning. Ask whether our approach to a RHIPW is inclusive.

MEMBERSHIP AND ROLES

The RHIPW Work Group will include broad cross-sector representation of the major systems that are involved in conducting community assessment activities and plans that address health and well-being in King County. The RHIPW will be co-led by Kris Lee and Kim Tully.

Initial Membership will initially comprise representatives from the following sectors/entities:

- Area Agency on Aging (Andrea Yip, City of Seattle Aging & Disability Services)
- City Government (Erica Azcueta, Auburn and Alaric Bien, Redmond)
- Community voice(s) (working on recruitment)
- Equity Network (Shelley Cooper-Ashford, Center for MultiCultural Health)
- Community Action Agencies (Kim Tully, Solid Ground)
- United Way of King County (Mary Shaw)
- Hospitals systems (Elizabeth "Tizzy" Bennett, Seattle Children's Hospital, ACH Leadership Council member)
- Housing & Community Development (Cheryl Markham, KC Department of Community & Human Services)
- Federally Qualified Community Health Centers (Susan Amberson, Neighborcare Health & Federico Cruz-Uribe, Sea Mar Health Centers)
- Managed care organization(s) (Kris Lee, Amerigroup Washington, Inc.)
- Mental health/substance abuse (Lydia Chwastiak, University of Washington)
- Seattle Indian Health Board (Aren Sparck, SIHB, Health Innovation Leadership Network member)
- Public Health-Seattle & King County (PHSKC) (Gloria Albetta, Manager, Assessment, Policy Development & Evaluation and Janna Wilson, Director of Health Policy and Planning)

- **Participation**

A monthly meeting series for the RHIPW will be established. The work group may decide to add, cancel, or modify meetings as appropriate throughout the year.

The co-leads will discuss objectives and materials for each meeting. Agenda and meeting materials will be distributed at least three business days in advance. The co-leads will facilitate meetings.

SCOPE AND DELIVERABLES

The RHIP work group proposes a work plan for July through the end of the year, beginning with the formation of the work group and establishment and approval of a charter, review of King County

community assessments and priorities and draft of a Regional Health Needs Inventory to leadership council in September, and a proposed approach to the development of a RHIP, including opportunities to incorporate the work that has already begun around the four "linked initiatives" – Familiar Faces, Communities of Opportunity, physical/behavioral health integration, and the Housing-Health Partnership – by the November 16th ACH Interim Leadership Council meeting. To this end, the RHIPW will:

- Compile, review and synthesize existing county-wide needs assessments conducted by various sectors to identify common regional priorities and strategies.
- Identify alignment with other ACHs' regional and Healthier Washington's state priorities.
- Inventory cross-sector initiatives (resources) that reflect the diverse communities and partners within the region and currently address priorities.
- Identify an approach for development of a future Regional Health Improvement Plan including opportunities to streamline regional assessment and planning activities.
- Recommend future role, home and structure of RHIP in 2016

The RHIPW will produce the following deliverables:

- Regional Health Needs Inventory
- Inventory of Regional Health Initiatives
- Recommended approach for the development of a RHIP
- A proposed future role, home and structure for the RHIPW in 2016
- Final report to the ACH Leadership Council summarizing 2015 work and next steps

DECISION MAKING

- **Decision Making Approach**

Achieving agreement and building trust among different partners is essential for success. The RHIPW will make decisions and recommendations using a *modified consensus* approach. The underlying assumption of this approach is that it is inherently better to involve every person in the decision making process, in order to reflect more accurately the will of the group. The modified approach does not entail multiple cycles of voting and discussion.

We will use a "thumbs up/thumbs down signal as a way of gauging members' positions.

- Thumb up = supports the proposal
- Thumb sideways = neutral or undecided
- Thumbs down = does not support proposal

In the event of a thumbs down vote, we attempt to resolve the issues through further discussion in a reasonable amount of time. The RHIPW will work to understand and integrate perspectives of all members. In those instances where members do not fully agree, both the vote count and the issues and/or themes that emerge will be recorded in the minutes to provide a comprehensive picture of the group's recommendation to the ILC.

Key decisions will be made in person at RHIPW meetings. Members will be provided with adequate advance notice about decision items. The RHIPW will attempt to reach consensus and if accomplished, this decision will be communicated by email to all absent RHIPW members, who will have 4 business days to submit their level of agreement to the RHIPW co-leads. If a member's response is not received by the end of the 4th business day, this implies consent on the behalf of this member. For more routine items, decision making may be conducted over email and/or phone.

King County Accountable Community of Health

ACH Regional Health Improvement Plan Workgroup

NAME AND AFFILIATION	SECTOR(S)
Susan Amberson Director of Grants and Compliance Neighborcare Health **Federico Cruz-Uribe** Vice President of Clinical Affairs Sea Mar Community Health Centers	*Federally qualified community health centers rep*
Erica Azcueta Veterans and Human Services Coordinator City of Auburn **Alaric Bien** Human Services Senior Planner City of Redmond	*City Government*
Elizabeth "Tizzy" Bennett Director, Guest Services and Community Benefit Seattle Children's Hospital	*Hospital systems*
Kris Lee Director of External Affairs Amerigroup Washington, Inc.	*Managed care organization(s)*
Cheryl Markham Strategic Policy Advisor, Director's Office King County Department of Community and Human Services	*Housing & community development*
Mary Shaw Director of Planning and Public Policy United Way	*United Way of King County*
Aren Sparck Government Affairs Officer Seattle Indian Health Board	*Seattle Indian Health Board*
Kimberlee (Kim) Tully Strategic Information Systems Manager Solid Ground	*Community action agencies/rep*
Andrea Yip Planning Supervisor City of Seattle Aging and Disability Services	*Aging*
Shelley Cooper-Ashford Governance Team, Healthy King County Coalition and Executive Director, Center for MultiCultural Health	*Equity Network/Coalition Partner*
TBD	*Mental health/substance abuse*
Gloria Albetta Manager, Assessment, Policy Development & Evaluation Public Health-Seattle & King County **Janna Wilson** Director of Health Policy and Planning Public Health-Seattle & King County	*Local public health*

King County Accountable Community of Health

Regional Health Improvement Plan Work Group Meeting Summary

July 23, 2015, 11:00 a.m. – 12:30 p.m.
Chinook Building, Conference Room 1311

Members Present:
Susan Amberson (Neighborcare Health), Erica Azcueta (City of Auburn), Elizabeth "Tizzy" Bennett (Seattle Children's Hospital), Alaric Bien (City of Redmond), Sara Doty (Sea Mar Health Centers, on behalf of Federico Cruz-Uribe), Kris Lee* (Amerigroup Washington, Inc.), Cheryl Markham (KC Department of Community & Human Services), Mary Shaw (United Way of King County), Kim Tully (Solid Ground), Andrea Yip (City of Seattle Aging & Disability Services)*

*ACH Leadership Council member

Members Not Present, no delegate:
Aren Sparck (Seattle Indian Health Board)
**Shelley Cooper-Ashford (Center for MultiCultural Health)*

Sectors not yet represented:
Mental health/substance abuse

Staff:
Gloria Albetta, Laurie McVay, and Janna Wilson (Public Health – Seattle & King County)

Guests:
David Buckley (Hopelink), Ellie Wilson-Jones (Sound Cities Association)

INTRODUCTIONS AND OBJECTIVES

Gloria Albetta reviewed the agenda and noted the meeting's objectives to get to know each other and to review the charter. Members introduced themselves, noting their history with needs assessment work. The participants reflected a wide range of experience, including assessment work in entities such as FQHCs, community action agencies, United Way, the aging system, city government, hospital systems, public health, and more. Janna Wilson provided an overview of the King County Accountable Community of Health (ACH) design phase and how the Regional Health Improvement Plan Work Group (RHIPW) fits into the overall goals of the ACH development in 2015. The premise of the ACH work is that there are high priority issues that require cross-sector work in order to move the needle on health and wellbeing in our region. The charge for the RHIPW is to 1) develop an inventory of assessments and their priorities and 2) identify an approach for the development a future Regional Health Improvement Plan.

Cross-sector work is difficult by nature. The challenge is focusing the efforts of multiple sectors on a collective result that they have a shared stake in. King County's Health and Human Services (HHS) Transformation plan is one example of this kind of work. Initiatives such as Communities of Opportunity, Familiar Faces, and housing-health partnerships all made significant progress in the past year in engaging multiple sectors in their work to improve outcomes related to health, housing, justice system involvement, economic opportunity, and more. In 2015, King County Hospitals for a Healthier Community – a collaborative of 12 hospitals and health systems and Public Health-Seattle & King County-- issued its first joint community health needs assessment. This cross-sector

work provides a starting point for the King County ACH and the RHIPW. In addition, there are many other health improvement activities and initiatives taking place in the region.

Questions facing this group are:

- How will the RHIP be used? What is it? What is it not? The state was not very prescriptive in the deliverable, and there is room to shape and contribute to what a successful approach would be.
- Is there a way to think about working toward a systematic articulation of a shared set of priority issues? The RHIP is not static, it will need to change and evolve over time.
- The State is looking at partnering with the Federal government via a Global Medicaid Waiver. If the waiver ends up tied to the ACH, then the RHIP might also inform Medicaid innovation investments as well as other health improvement interventions.

Janna distributed a copy of the infographic, Invest *In Your Community: 4 Considerations to Improve Health & Well-Being for All (http://www.cdc.gov/chinav/docs/chi_nav_infographic.pdf)* and opened up the conversation for thoughts and questions from the members. The topics discussed included:

- The King County HHS Transformation initiatives are, in part, being used to inform the development of the ACH. The ACH and RHIP work are not limited to those efforts or issues.
- The Performance Measurement work group (PMW) has been formed and their work, which could be helpful in determining the RHIP priorities, is progressing
- Statewide coordination is going to important across the nine ACH regions. There has been some preliminary discussion with the State about assuring that there are some common priorities that ACHs are working on across the state that are consistent with the statewide set of common performance measures. .
- Among the regional ACHs that are still in the development stage, one participant noted that King County seems far along and very organized.
- The RHIPW's charge is to come up with recommendations for an approach to the development of a future Plan – not to prepare a plan. .
- The state's planning for a global Medicaid waiver is anticipated to be within the timeframe of this group's work. However, it is important to note that the ACH and RHIP work is being done in conjunction with Healthier Washington; its efforts are casting a wide net (beyond the Medicaid population) and will move forward regardless of the outcome of the global waiver (which is focused on Medicaid).
- King County, via the Assessment, Policy Development & Evaluation group, has a plethora of data. Yet, there are many other sources of data that could be tapped.

REVIEW OF CHARTER AND SCOPE OF WORK

Gloria led the discussion on the draft RHIPW charter. She noted that the charter is essentially a roadmap of the work that will be done by the RHIPW. The draft charter was developed by Gloria as a conversation starter and was set up similar to the ACH Interim Leadership Council's (ILC) and the PMW's charters. The discussion was opened up for comments, questions, and suggestions. The topics discussed included:

Deliverables

The scope includes three (3) main deliverables:

1. Submit a Regional Health Needs Inventory to the ILC in September. This requires taking inventory of King County regional health initiatives, community assessments, and priorities.
2. Recommend an approach for the development of a Regional Health Improvement Plan at the November 16 ILC meeting. The plan should include a proposed future role, home, and structure for the RHIPW in 2016.
3. Submit a final report to the ACH Leadership Council summarizing 2015 work and proposed next steps.

Challenges

- .
- How will we avoid getting lost in all the initiatives, and avoiding duplication? The RHIPW determines the approach which could include phased steps.
- How do we engage with the community? Even though we are only developing an approach and not the actual plan, community voice in shaping this is needed at each stage. Steps are underway to reach out to invite community member(s) to join the work group.
- There are ongoing discussions regarding filling the substance abuse and mental health sector seat on the work group.

Leadership and Decision Making

Kris Lee and Kim Tully agreed to act as co-leads for the work group. Their primary responsibility will be to work with Gloria on developing the meeting agendas.

The RHIPW will be making decisions on what to recommend to the ILC. They determined the most effective form of voting would be a modified consensus approach using a "thumb" vote: thumb up for yes, thumb sideways for undecided or ambivalent, and thumb down for no. Silence will be taken as consent. The vote count and the issues and/or themes that emerge will be recorded in the minutes so as to provide a complete picture of the group's recommendation to the ILC.

Some members requested additional time to digest the draft charter. Any additional feedback or thoughts on the charter should be sent to Gloria Albetta by the end of the day on Friday, July 31.

NEEDS SUMMARY

Gloria Albetta drafted a summary of health needs priorities that were identified through a review of strategic plans and assessments conducted during 2013 through 2015. The document was shared with the ILC for their preliminary review and will be included in the application for ACH designation being submitted to the State at the end of August. The group reviewed the document and shared suggestions for additional assessments and priorities, desired aspects of priorities (asset based rather than need based), and potential challenges; including:

- Additional assessment resources
    - Age Friendly Cities Framework
    - Keeping abreast of other community action agencies' lessons and strategies in approaching their needs assessment projects

  - Private sector, e.g. bank and philanthropic, strategic plans may have value to add. It was noted that corporate strategic plans are not always aligned with overall population needs.
  - Comprehensive plans prepared by cities.
- Good geographical coverage is needed
- Engagement of the communities and faith-based organizations
  - There are better outcomes when change is owned at the grass roots level.
- The RHIP process should include an opportunity to look at community strengths and assets
  - Janna noted that Chicago has done amazing work in asset mapping by partnering with youth employment programs. It is an ongoing project providing employment for youth.
- Indicator projects, e.g. Communities Count, do not identify priorities and will not be part of the inventory.

IDENTIFY NEXT STEPS

Gloria will work with co-Leads Kris Lee and Kim Tully to plan the agenda for the next meeting scheduled for Thursday, August 20 from 12:00 – 2:00 pm.

MEETING ADJOURNED AT 12:32 P.M.

DRAFT DRAFT Summary of Priorities Identified Through Assessments 2013-2015 DRAFT DRAFT

	Documents																												
DRAFT Topics and Subtopics	**NOT FOR DISTRIBUTION Please email gloria.albetta@kingcounty.gov if you know of other assessments**	DRAFT Area Plan on Aging, Seattle-KC, 2016-2019	Auburn Buidling a Healthier Tomorrow: Health Equity and Access in Auburn 2014	APICAT Community Assessment	CEH Strategic Plan	Healthy Tribal and Urban Indian Communities: The Journey Forward, July 2013	HHC-Hospitals CHNA 2015-2016	KC Comp Plan to Prevent & End Youth & Young Adult Homelessness by 2020, May 2015	KC Consortium Consolidated Housing & Community Development Plan 2015-2019	KC HHS Transformation Plan 2014-2018	KC Housing Authority Moving to Work Plan 2015	KC Public Perspectives & Priorities for the Future of King County 2014-2017	KC Youth Action Plan April 2015	PSESD Early Learning Programs 2014 Community Assessment	Renton Community Needs Assessment for Human Services & Housing, June 2014	Seattle Children's Results of Family Listening Groups & Community Stakeholder Input 2014-2015	Seattle Health & Equity Assessment December 2014	KC Countywide Planning Policies	KC Local Food Initiative	KC Comprehensive Plan	Seven Steps to Enhance HIV Community Services in WA State: A Plan Forward, June 2015	Solid Ground Community Needs Assessment December 2014	Together We Can Lift Up the Sky: A Vision for the Urban Indian Community, 2014	United Way of King County Strategic Plan	WA DOH MCH Block Grant Community Survey 2014	TOTAL	TOTAL CATEGORY
	Aging Population																												
	Access to chronic care management (CCM)	X								X						X											3	
	Livable Communities	X													X	X											3	
	Falls prevention	X																									1	
	Housing for low-income seniors	X																									1	
	Pre-Medicaid Services	X																									1	
	Children & Youth																												
	Adverse Childhood Experienced (ACEs)									X			X			X									X	4	
	Early parent support, resources and education (home visits)									X			X		X	X									X	5	
	Community Development																												
	Community & public safety						X		X	X		X				X				X						6	
	Livability & sustainability	X							X									X	X	X						1	
	Economic vitality								X	X		X						X	X	X						6	
	Equity - Social Determinants of Health																												
	Poverty	X						X	X					X		X		X		X				X		8	
	Food insecurity and lack of nutritional education					X	X		X	X				X	X	X		X	X	X				X		11	
	Access to living wage jobs and employment training					X	X	X	X	X	X	X	X		X			X	X	X		X	X		X	15	
	Criminal Justice		X		X			X		X		X	X									X				7	
	High quality education including early learning				X			X		X	X		X	X	X	X		X		X		X	X	X		13	
	Language access									X						X		X		X						4	

DRAFT DRAFT Summary of Priorities Identified Through Assessments 2013-2015 DRAFT DRAFT

	Documents																													
DRAFT Topics and Subtopics	**NOT FOR DISTRIBUTION Please email gloria.albetta@kingcounty.gov if you know of other assessments**	DRAFT Area Plan on Aging, Seattle-KC, 2016-2019	Auburn Buidling a Healthier Tomorrow: Health Equity and Access in Auburn 2014	APICAT Community Assessment	CEH Strategic Plan	Healthy Tribal and Urban Indian Communities: The Journey Forward, July 2013	HHC-Hospitals CHNA 2015-2016	KC Comp Plan to Prevent & End Youth & Young Adult Homelessness by 2020, May 2015	KC Consortium Consolidated Housing & Community Development Plan 2015-2019	KC HHS Transformation Plan 2014-2018	KC Housing Authority Moving to Work Plan 2015	KC Public Perspectives & Priorities for the Future of King County 2014 2017	KC Youth Action Plan April 2015	PSESD Early Learning Programs 2014 Community Assessment	Renton Community Needs Assessment for Human Services & Housing, June 2014	Seattle Children's Results of Family Listening Groups & Community Stakeholder Input 2014-2015	Seattle Health & Equity Assessment December 2014	KC Countywide Planning Policies	KC Local Food Initiative	KC Comprehensive Plan	Seven Steps to Enhance HIV Community Services in WA State: A Plan Forward, June 2015	Solid Ground Community Needs Assessment December 2014	Together We Can Lift Up the Sky: A Vision for the Urban Indian Community, 2014	United Way of King County Strategic Plan	WA DOH MCH Block Grant Community Survey 2014	TOTAL	TOTAL CATEGORY
	Health Care Delivery System																													
	Access to preventive services and specialty care						X	X		X					X	X							X		X	7	
	Access to dental care						X			X					X	X									X	5	
	Access to behavioral health					X	X	X		X			X		X	X									X	8	
	Early childhood screenings and parental support					X	X			X			X			X									X	6	
	Integration & Coordination of Care	X					X			X			X			X										4	
	Culturally competent workforce			X			X	X		X						X										5	
	Housing (Prevention, Intervention, Placement, Stabilization & Support)																													
	Affordability – (preserve and expand inventory of decent, safe, and healthy affordable housing)	X	X		X	X	X	X	X	X	X	X	X	X	X	X		X		X		X	X		X	19	
	Affordable housing policy/regional planning				X			X	X		X							X		X						6	
	Expand range of housing/affordable housing types & options; i.e.rapid rehousing, diversion, rapid supportive housing, host homes & emergency short term housing for youth with high needs, etc		X		X			X	X	X	X					X		X		X				X		10	
	Supportive services as needed for housing stability, and especially for chronically homeless and homeless yya				X			X	X	X	X					X		X		X						8	
	Preventable Causes of Death																													
	Obesity						X			X						X			X				X			5	
	Tobacco use					X	X			X						X										4	
	Access to affordable, healthy food		X	X		X	X		X	X			X		X	X			X	X				X	X	13	
	Access to physical activity opportunities	X	X	X		X	X		X	X						X		X		X					X	10	
	Transportation - Geographic Mobility																													
	Access to safe and efficient public transit		X				X		X	X	X	X			X	X		X		X						10	
	Safe pedestrian/bike pathways		X			X	X		X	X		X			X			X		X						9	

PATHWAY FOR SUSTAINABILITY PLANNING

- Draft Scope: Sustainability Work Group

King County Accountable Community of Health Design
DRAFT SCOPE: Sustainability Workgroup

Background

An initial path for sustainability is one of the required deliverables of the Health Care Authority 2015 Design contract. This scope is still to be completed, but the following is general background. No staff resources to support this work have yet been identified.

The ACH work plan that was developed for the grant application called for development of a sustainability/shared savings work group, and the achievement of the following objectives:

- Strengthen partnerships with philanthropic organizations, managed care plans, community development entities, community benefit hospitals, and county and state government to enable discussions during the year about the different mechanisms for financing cross-sector health improvement efforts, & financing ACH infrastructure.
- Develop a draft sustainability concept document, for discussion by the ACH Interim Leadership Council, and inclusion as element of ACH Readiness Proposal.
- For at least one initiative, develop a mutually agreeable approach to identifying, capturing, and reinvesting shared savings.

ADDITIONAL ACTIVITIES

- Position Description: Physical and Behavioral Integration Manager

King County

Invites Applications for the Position of:

Physical and Behavioral Health Integration Manager/Project Program Manager IV

Apply online at http://www.kingcounty.gov/jobs

King County is committed to equity and diversity in the workplace. In addition, the county is committed to recruiting and maintaining a quality workforce that shares our guiding principles: collaborative, service-oriented, results-focused, accountable, innovative, professional and fair and just.

OPENING DATE/TIME: 08/05/15 12:00 AM (GMT -8:00)

CLOSING DATE/TIME: 08/18/15 04:30 PM (GMT -8:00)

SALARY: $7,215.87 - $9,145.07 Monthly

LOCATION: Chinook Building - 401 5th Ave, Seattle

JOB TYPE: Term Limited Temporary, Full Time, 40 hrs/wk

DIVISION: Department of Community & Human Services

JOB NUMBER: 2015SC5035

SUMMARY:

The Department of Community and Human Services (DCHS) is dedicated to helping our region's neediest residents achieve and maintain healthier and more independent lives and to strengthening our communities. This position will be with DCHS although it will coordinate across multiple departments of the county.

The responsibilities of the Physical and Behavioral Health Integration Project Manager include providing leadership, project management, and direction to multiple highly visible, complex projects related to integrating physical health, mental health, substance use disorder treatment, and other human services for King County. This includes assisting King County and its community partners to develop an integrated design model and critical path forward, including key milestones and timelines to achieve implementation of an integrated model before January 2020. It also includes providing project management support to a related initiative, the Familiar Faces work of the King County Health and Human Services Transformation Plan. The position will involve coordination with a range of stakeholders and community leaders from different community, business, and governmental sectors in health, behavioral health and human services. This dynamic, outcome-oriented leader will work as part of a larger county health and human services system transformation team to move forward the vision of the County's Health and Human Services Transformation efforts.

Duration: This is projected to be a 2 year full time Term-Limited Temporary (TLT) position.

Who may apply: This position is open to all qualified candidates that meet the minimum

qualifications. The Department of Community and Human Services values diverse perspectives and life experiences. The Department encourages people of all backgrounds to apply, including people of color, immigrants, refugees, women, LGBTQ, people with disabilities and veterans.

Required materials: Candidates who wish to be considered for this position must submit an on line King County job application and complete the supplemental questionnaire.

Work Schedule: Typical hours are Monday - Friday, 8:00am - 5:00pm. This position is exempt from overtime.

Recruiter: Susan Churchill, email: susan.churchill@kingcounty.gov

JOB DUTIES:

Working as part of a cross-departmental team and in conjunction with the overall physical and behavioral health initiative lead:

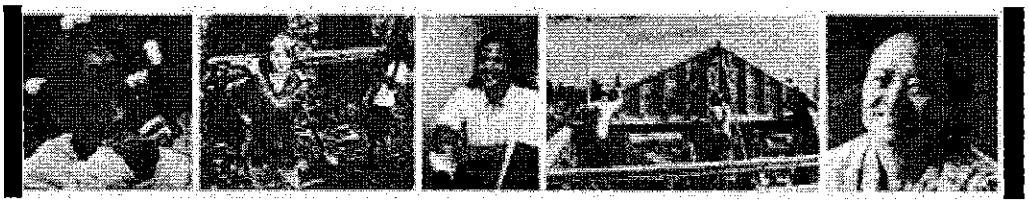
- Coordinate the start-up and functioning of a cross-sector Physical and Behavioral Health Integration (PBHI) Design Committee and associated work groups, including the Familiar Faces Initiative. Working in partnership with a consultant facilitator and other lead staff, assure the development and use of effective charters or MOUs, operating agreements, work plans, and deliverables. Together with the Physical and Behavioral Health initiative lead, assure monitoring the status of all components of the work, and provide regular status reports to internal and external audiences. Flag issues that may need attention from colleagues, leadership or the Design Committee members to remove barriers.
- Develop strong working relationships with Design Committee members; work to understand perspectives and create an environment of mutual respect, trust, and buy-in. Support the committee members in identifying potential conflicts of interest and methods for addressing. Support the committee members in developing and using a mutually agreed upon decision making process throughout the course of their work. Maintain a perspective of neutrality whenever possible.
- Monitor and research national and international trends to ensure currency of knowledge, and that advice, policy development, service delivery reforms or major initiatives are responsive to and reflective of current competitive practices and contextual factors.
- Work with other relevant transformation team leads and the integration consultant facilitator to conceptualize critical paths for achievement of an integrated care model design, gather and analyze feedback and information, develop outcome-based agendas, and facilitate meetings where appropriate. Support the PBHI Design Committee in having effective discussions regarding future physical and behavioral health integration design models and other decision making. Anticipate and resolve potential barriers.
- Assess needs for technical expertise and consultation throughout the project. Make recommendations for and procure consultant services, within available budget. Manage consultant contract bodies of work in support of the integration work.
- Assure team members are clear on their specific roles, deliverables, and accountabilities relative to the overall physical and behavioral health integration work plan. Foster good communication among team members with integration-related responsibilities. Participate in team meetings and huddles to support strong communication and coordination across the larger portfolio of transformation-related initiatives.
- Prepare straw proposals, briefing documents, speaking points, presentations, reports, applications, budgets and/or other documents associated with moving work plans forward. Working with communications and administrative support team members, assure an effective website and other communication tools and practices are in place.
- Participate as a member of the core staff team and coordinate the PBHI and Familiar Faces work with the overall Accountable Community of Health (ACH) work and other transformation activities and act as liaison to the ACH Leadership Council when appropriate.

- Participate as a member of the PBHI staff team in interagency committees and task forces related to physical and behavioral health integration at both the state and local level and provide information and advice regarding physical and behavioral health integration.
- Help to drive policy priorities through government and legislative processes and collaborate on problem solving of key issues as they arise. Ensure the County's resources are deployed appropriately and efficiently to maximize outcomes.
- Perform other related duties as assigned.

EXPERIENCE, QUALIFICATIONS, KNOWLEDGE, SKILLS:

1. Advanced technical expertise in facilitating cross-sector planning in the health, behavioral health, and/or human services fields and managing groups with multiple perspectives and competing interests to reach a shared goal.
2. Demonstrated track record having worked successfully with diverse public and private stakeholders in a politically complex environment.
3. Demonstrated knowledge of current reform agendas and integration strategies, particularly related to physical and behavioral health care integration.
4. Demonstrated knowledge of Medicaid managed care and integrated care models.
5. Demonstrated facilitation, negotiation, and consensus-building skills.
6. Advanced project management skills including experience leading multiple projects and tracking activities and deliverables to move projects forward and achieve outcomes.
7. Broad knowledge of public policy and of the health/behavioral health and human service systems.
8. Analytical and problem-solving skills.
9. Advanced oral and written communication skills, including presentation and public speaking; ability to present complicated issues in an accessible manner to diverse audiences.
10. Ability to effectively manage time to work on multiple tasks in a high pressure/short deadline environment, and to adapt to changes in work load demand and priorities.
11. Ability to effective work in a team environment including strong interpersonal and human relations skills, including conflict resolution techniques.
12. Proficiency in the use of personal computers and of 2010 MS Word, Excel, Access, Outlook and the Internet.
13. DESIRED: Three years of experience integrating physical and behavioral health in a managed care environment. Experience delivering integrated physical and behavioral health services to diverse populations including racial and ethnically diverse and economically diverse residents.

SUPPLEMENTAL INFORMATION:



Note: Online applications are preferred. However, if you cannot apply online, go to www.kingcounty.gov/jobs for other options.

If you need an accommodation in the recruitment process or an alternate format of this announcement, please inquire directly with the contact listed on the job announcement or the department's Human Resources Service Delivery Manager.

Physical and Behavioral Health Integration Manager/Project Program Manager IV Supplemental Questionnaire

* 1. Describe your experience in facilitating cross-sector planning in the health, behavioral health, and/or human services fiends and managing groups with multiple perspectives and competing interests to reach a shared goal. Please include your title and organization name.

* 2. Describe your experience and knowledge of Medicaid managed care and integrated care models.

* 3. King County has transformed its work on equity and social justice from an initiative to an integrated effort that applies the principle of "fair and just" intentionally in all the county does in order to achieve equitable opportunities for all people and communities. What is the most important equity or social justice issue to you?

* Required Question